SaxInstitute

Interim Evaluation Report

Evaluation of the *Supporting the Primary Care Sector Response to Family, Domestic and Sexual Violence Primary Health Network* Pilot

An independent report prepared by the Sax Institute for the Australian Department of Health, Disability and Ageing - October 2025

Acknowledgement of Country:

The Sax Institute acknowledges the Gadigal People of the Eora nation as the first peoples and traditional owners of the land on which the Sax Institute office is located. We pay our respects to Aboriginal Elders past, present and emerging. We recognise the strong cultural connections of all First Peoples to their land and water across Australia.

Knight, A., Economidis, G., Li, V., Newell, S., Ninnes, P. Interim Evaluation Report for the Evaluation of the Supporting the Primary Care Sector Response to Family, Domestic and Sexual Violence Primary Health Network Pilot. Sydney: Sax Institute 2025.

Enquiries regarding this report may be directed to:

Dr Alice Knight
Director, Evaluation and Evidence Services, Sax Institute
www.saxinstitute.org.au
Alice.Knight@saxinstitute.org.au
Phone: 0416 817 017

Contents

List of Tables

List of Figures

Acronyms and glossary of terms

ACCHO	Aboriginal Community Controlled Health Organisation
ACTPHN	Australian Capital Territory Primary Health Network
A-LIVES	Aware, Alert, Ask and Listen, Inquire, Validate, Enhance Safety, Support
AMS	Aboriginal Medical Service
BSPHN	Brisbane South Primary Health Network
CALD	Culturally and linguistically diverse
CAWLS	Central Australian Women's Legal Service
CCDVCAS	Central Coast Domestic Violence Court Advocacy Service Inc.
CESPHN	Central and Eastern Sydney Primary Health Network
CI	Confidence interval
CoP	Community of Practice
COVID-19	Coronavirus disease
CPD	Continuing professional development
CRARMF	Common Risk Assessment and Risk Management Framework
CRCC	Canberra Rape Crisis Centre
CRM	Customer Relationship Management
CSA	Child sexual abuse
DFSV	Domestic, family and sexual violence
DFV	Domestic and family violence
DHDA	Department of Health, Disability and Ageing
DV	Domestic violence
DVCS	Domestic Violence Crisis Service
FDSV	Family, domestic and sexual violence
FV	Family violence
GP	General Practitioner
HNECCPHN	Hunter New England and Central Coast Primary Health Network
IPV	Intimate partner violence
LHD	Local health district
KEQ	Key Evaluation Question
LEAN	Lived Experience Advisory Network
LELAN	Lived Experience Leadership & Advocacy Network

LEAP	Lived Experience Advisory Panel
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual/Aromantic
MARAM	Multi-agency Risk Assessment and Management
MR	Mandatory reporting
MRG	Mandatory Reporter Guide
NBMPHN	Nepean Blue Mountains Primary Health Network
NMBA	Nursing and Midwifery Board of Australia
NT	Northern Territory
NTPHN	Northern Territory Primary Health Network
NWMPHN	North Western Melbourne Primary Health Network
PHN	Primary Health Network
PSS	Personal Safety Survey
PUVA	Persons using violence/abuse
QI	Quality improvement
QIA PDSA	Quality Improvement Activity using a Plan-Do-Study-Act (PDSA) cycle
RACGP	Royal Australian College of General Practitioners
RRR	Recognise, Respond, Refer
SAPHN	South Australia Primary Health Network Consortium
SARC	Sexual Assault Referral Centre
SASS	Sexual Assault Support Service
SAVADA	Spot the Signs, Ask the Questions, Validate and Believe, Assess the Risk, Document and Act on Referrals
SD	Standard deviation
SPC Pilot	Supporting Primary Care Response to Family, Domestic, and Sexual Violence Pilot
SV	Sexual violence
TASPHN	Tasmania Primary Health Network
WAPHA	Western Australia Primary Health Alliance
WDVCAS	Women's Domestic Violence Court Advocacy Services
WVPHN	Western Victorian Primary Health Network
Primary care workforce	Health practitioners, including general practitioners (GPs), practice nurses, allied health professionals, administrative staff (including practice managers, receptionists and other practice support staff)
System Integrator	An individual, typically employed by a specialist FDSV service or other suitable organisation (e.g., Local Health Network or Aboriginal Medical Service), with expertise in the area of FDSV, whose role is to improve integration, coordination

	and referrals to and between primary care and specialist FDSV services. System Integrators are variously referred to as Linkers, Local Links, Connectors or Navigators across PHNs
Specialist FDSV service	Services that engage directly with victim-survivors, perpetrators and families when FDSV has occurred.

Executive summary

Overview of the SPC Pilot

The Supporting Primary Care Response to Family, Domestic, and Sexual Violence Pilot (SPC Pilot) aims to improve the primary care workforce's ability to recognise and respond to FDSV, increase referrals to specialist services, enhance collaboration between health and support sectors, and ensure equitable, effective support for all victim-survivors.

Key stakeholders involved in the SPC Pilot

Primary care workforce: Health practitioners, including general practitioners (GPs), practice nurses, allied health professionals, administrative staff (including practice managers, receptionists and other practice support staff) who interact with, or care for, victim-survivors in their day-today roles.

System Integrator: An individual, typically employed by a specialist FDSV service or other suitable organisation (e.g., Local Health Network or Aboriginal Medical Service), with expertise in the area of FDSV, whose role is to improve integration, coordination and referrals to and between primary care and specialist FDSV services. System Integrators are variously referred to as Linkers, Local Links, Connectors or Navigators across PHNs.[1]

Specialist FDSV service: Services that engage directly with victim-survivors, perpetrators and families when FDSV has occurred.

Primary Health Network (PHN): PHNs are independent organisations funded by the Australian Government to coordinate primary care locally and commission services where there are healthcare gaps. PHNs play a key system integration role in the SPC Pilot, connecting primary care and specialist service sectors, and enabling important system-level changes to enhance implementation and impact of Pilot activities.

The SPC Pilot takes a whole-of-practice approach to encourage a climate of disclosure, recognition and response at the practice-level, and allows for flexibility of implementation so that each PHN can tailor an approach that meets their local needs and service context. The core components and activities of the SPC Pilot, are:

1. **Capability building**: Delivery of training, resources, and capability-building activities for primary care staff to enhance their ability to recognise and respond to FDSV

[1] All but one PHN (NWMPHN) adopted this model of commissioning a specialist FDSV service who employed a System Integrator. NWMPHN instead commissioned secondary consultation services from specialist FDSV services and experts from the University of Melbourne to support this aspect of their model.

2. **System Integration**: Employing dedicated System Integrator[2] roles to act as conduits between primary care and specialist FDSV services, to improve integration, coordination and referrals to and between the primary care and the FDSV sector,
3. **Influencing the system for sustainable change:** Influencing broader systems change by ensuring key system stakeholders can come together (e.g., via Communities of Practice or networking events) to jointly work on overcoming systemic barriers to change.

As summarised below, the SPC Pilot supports 12 PHN regions; 11 (through consortium arrangements) now support a Pilot for FDSV and CSA and one PHN (North Western Melbourne PHN) supports a Pilot for FDV only.

Established PHNs

- Brisbane South PHN (BSPHN)
- Central and Eastern Sydney PHN (CESPHN)
- Hunter New England and Central Coast PHN (HNECCPHN)
- Nepean Blue Mountains PHN (NBMPHN)
- North Western Melbourne PHN (NWMPHN)
- Western Victoria PHN (WVPHN)

New PHNs

- Adelaide PHN, in consortium with Country South Australia PHN (SAPHN Consortium)
- Australian Capital Territory PHN (ACTPHN)
- Northern Territory PHN (NTPHN)
- Tasmania PHN (TASPHN)
- Western Australia Primary Health Alliance (WAPHA), responsible for delivery of the Pilot in Perth South PHN

Overview of the evaluation

This interim report provides initial findings of the evaluation and aims to:

1. To describe the training, resources, capability building supports, and system integration activities implemented in each PHN (activities of components 1 and 2), and levels of participation in, or engagement with, these activities.
2. To understand stakeholder perceptions of the SPC Pilot activities, specifically in relation to any perceived enablers or barriers to implementation or participation.
3. To explore early outcomes in relation to primary care's ability recognise and respond to FDSV.
4. To identify preliminary insights and recommendations.

[2] An individual, typically employed by a specialist FDSV service or other suitable organisation (e.g., Local Health Network or Aboriginal Medical Service), with expertise in the area of FDSV, whose role is to improve integration, coordination and referrals to and between primary care and specialist FDSV services.

Key evaluation findings

Aim 1

> To describe the training, resources, capability building supports, and system integration activities implemented in each PHN (activities of components 1 and 2), and levels of participation in, or engagement with, these activities.

Between July 2022 and April 2025, PHNs delivered 721 FDSV training sessions to 3,751 participants in 12 PHN regions across Australia. The largest group of participants were general practitioners (45%), followed by nurses (19%), receptionists (11%), practice managers (7%), administrative staff (4%), and allied health professionals (1%).

The type of training delivered varied, with the most common training package being 'Recognise, Respond, Refer' which accounted for 16% of all training delivered in the reporting period. Some PHNs developed bespoke training modules that focused on specific issues, such as coercive control, and others co-designed culturally safe and appropriate training packages for priority populations, such as the Wanga Laka Project in WVPHN. PHNs also developed a diverse range of resources to enhance clinical practice and patient engagement, including action plans, referral directories, flowcharts, pocket guides, posters, and multimedia tools.

PHNs employed various strategies to improve system integration across the primary care and specialist FDSV sectors. As a first step, all PHNs dedicated a significant amount of time ensuring their HealthPathways[3] were up to date and included referral options for sexual violence (SV), and child sexual abuse (CSA) services. The role of System Integrators was critical for supporting primary care staff to improve their ability to recognise and respond to FDSV, with 8,446 meaningful interactions recorded between System Integrators and primary care staff across 1,124 practices. PHNs also established Communities of Practice (CoPs) and facilitated networking events to enable peer support and reflective learning across PHNs, and they supported the co-location of specialist FDSV staff in primary care clinics to provide timely support and guidance when needed.

Aim 2

> To understand perceptions of the SPC Pilot activities, specifically in relation to acceptability, experience, and any perceived enablers or barriers to implementation or participation

There was strong support for the SPC Pilot across all interviewed stakeholder groups. They viewed the training as useful and acceptable, particularly when a whole-of-practice approach was used and engaged both clinical and non-clinical staff and emphasised shared responsibility across all roles in the practice. Flexible delivery was also valued and seen as particularly important for engaging busy GPs, as was the inclusion of practical examples and tools, and the voice of victim-survivors, because it helped translate abstract theory into real-life practice change. Some non-clinical staff expressed a

[3] HealthPathways are free, online platforms offering the primary health workforce empirical advice on the assessment and management of various health presentations, including referral guidance to commensurate services, where relevant.

desire for more practical, applied training content tailored to their non-clinical roles, whilst a subset of interviewed clinicians indicated that they would appreciate more training in complex areas such as coercive control, mandatory reporting for children, and elder abuse.

The role of System Integrators was widely reported to be a critical enabler of implementation. Primary care staff described them as approachable, responsive and a trusted first contact that provided post-training support, secondary consults and clear guidance about local referral pathways. Interviewees emphasised that they provided readily available advice (by phone, email or in person) which improved their confidence to recognise and respond to FDSV and enabled them to make warm referrals particularly in time-sensitive situations. System Integrators were also valued for "showing up" to inter-agency meetings and for sharing up-to-date FDSV system knowledge, which strengthened relationships between the primary care and specialist FDSV sectors. The CoPs that PHNs established and inter-agency meetings and networking opportunities, were viewed as an "accelerator" for practice improvement and credited for normalising conversations about FDSV and fostering a culture of learning, instead of competition between PHNs.

Barriers to implementation were largely structural or administrative in nature. Interviewees reported workforce churn, particularly high GP turnover, as undermining the sustainability of practice capability improvements, and the time and financial costs of clinic closures for training as being a disincentive for participation and engagement with the SPC Pilot. Fragmented referral processes and inconsistent communication between DFV, SV and CSA services, as well as inconsistent feedback from specialist FDSV services to GPs, were also common challenges, with GPs reporting they were often uncertain whether their referrals were received, actioned or closed. Finally, limited integration of referral tools in primary care clinical software was also reported as contributing to administrative burden and potential safety and medico-legal risks.

Aim 3

> To explore early outcomes achieved at the primary care level in relation to their ability recognise and respond to FDSV

Early findings of the evaluation indicate that the SPC Pilot has strengthened primary care's ability to recognise and respond to FDSV. Survey data indicate statistically significant improvements in primary care staff's ability to recognise patients experiencing FDSV, and ability to respond to patients experiencing FDSV or patients using violence and abuse. Primary care clinicians recorded the largest response gains. Primary care clinician survey respondents also reported statistically significant improvements in their understanding of the role primary care plays in supporting patients experiencing FDSV. Their familiarity with FDSV-related guidelines, legislation, and policies had also improved significantly at follow-up.

Between July 2022 and April 2025, there had been 1,513 direct client referrals from primary care staff to specialist FDSV services, with the majority of referrals involving DFV victim-survivors (95%). Almost all individuals referred were female, more than half were in their 30s and 40s, and a fifth (n=303) identified as Aboriginal and/or Torres Strait Islander, highlighting both the need for, and the importance of, culturally safe referral pathways.

Although early evaluation findings indicate that the SPC Pilot has improved outcomes for the primary care workforce, it is too early to definitively assess its impact on victim-survivor outcomes. A final evaluation report (due early 2027) will include a more comprehensive analysis of outcomes for victim-survivors.

Aim 4

To identify preliminary insights and recommendations

Both interview and survey data show increased awareness, knowledge, and confidence among primary care staff to recognise and respond to FDSV, especially for FDV. As the Pilot continues and PHNs are further along in their implementation of activities aiming to improve recognition and response to SV and CSA, it is likely these areas will see a similar improvement.

A whole-of-practice approach was reported to be critical for fostering culture change in practices and empowering all staff to feel responsible and confident to recognise and respond to FDSV. Similarly, System Integrators were perceived as being 'the glue', providing trusted advice, warm referrals and locally relevant referral pathways and knowledge that helped bridge the gap between primary care and specialist FDSV services.

Training participation amongst practice managers was relatively low. This finding could be because practice managers were too busy to attend, or because there were fewer practice managers to recruit for the training in each PHN (i.e., there is typically only one practice manager employed per practice, but multiple GPs and nurses).While GPs represented the largest group of training attendees in most PHNs, in NTPHN, nurses attended more sessions than any other group. This is not surprising given the over-representation of nurses, Remote Area Nurses (RANs) and AHWs in the primary care workforce in the NT, and the well-established challenges related to recruiting and retaining GPs in rural and remote areas.

Finally, victim-survivors who identified as Aboriginal or Torres Strait Islander were disproportionately represented in the referrals to specialist FDSV services (i.e., 1/5 of all referrals). This over-representation should not be framed as a deficit, rather, it signals the SPC Pilot is providing culturally safe ways of recognising and responding to FDSV for at-risk populations.

Based on these key insights and the findings of this interim evaluation, we have developed the following recommendations for consideration:

Sustainability and workforce

1. Continue providing trauma-informed FDSV training at the whole-of-practice level and ensure it is offered flexibly, delivered in short blocks of time (e.g., no longer than 2-hour per session), and scheduled well in advance to accommodate the availability and preferences of primary care staff. Flexibility is particularly important for GPs who work in smaller practices, who may experience loss of income if they need to close their practice to participate.
2. PHNs that are new to the SPC Pilot highly value the support offered by existing PHNs (e.g., the CoPs, resource sharing, networking opportunities). Ensure this continues as it is perceived to be strengthening their implementation and the activities they are delivering.

3. Encourage PHNs to communicate to GP and nurse training participant's that they can earn continuing professional development (CPD) points for completion of FDSV training, as required by the Royal Australian College of General Practitioners (RACGP) and the Nursing and Midwifery Board of Australia (NMBA).

Victim-survivor voice and outcomes

4. Embed the voice of victim-survivors in training through role playing, and, where possible, ensure training is developed and/or co-facilitated by either a GP, nurse, Aboriginal Health Worker, or a System Integrator with specialist expertise in FDSV.

5. Whilst some PHNs have co-developed training packages and resources for priority populations with organisations who advocate for the rights of these priority populations (e.g., WVPHN's Wanga Laka First Nations Family Violence program), continue to encourage other PHNs to do the same. Particularly as the referral data indicated that there is clearly a need for support amongst First Nations victim-survivors to have access to culturally safe specialist support.

6. Continue exploring opportunities to improve awareness and knowledge of FDSV areas that have traditionally been difficult to address, such as coercive control, elder abuse and child and sexual violence.

System integration and equity

7. To help close the referral 'feedback loop', consider developing standardised referral templates that can be integrated into routine practice management systems (e.g., Best Practice, MedicalDirector, Communicare), and establishing similar templates and/or processes for specialist FDSV service staff to make it easier for them to feedback to health practitioners on the outcome of their referrals. This would improve continuity of care, and ensure safer, timely follow-up for patients, particularly where child protection issues are involved.

8. Support PHNs to document clear processes and procedures related to their model, to ensure that there can be continuity of implementation and knowledge transfer should staff leave or change, both in the PHN and their commissioned service. Support should be prioritised for PHNs servicing regional and remote areas given they are more vulnerable to recruitment challenges and high staff turnover.

9. Although there has traditionally been a focus on improving the ability of GPs to recognise and respond to FDSV, the SPC Pilot has taken a broader focus, and empowered PHNs to tailor and adapt their models so they are appropriate for the local context and needs of the populations they serve. This is clearly a strength of this Pilot, as evidenced by the model implemented in NTPHN. Ensure that this local adaptation and tailoring of the model is encouraged across all PHNs.

Introduction

Family, domestic and sexual violence (FDSV)

Violence against women and their children is a fundamental breach of human rights, a criminal offence, and has significant social, psychological, health and economic costs for the community. The 2021-2022 Personal Safety Survey (PSS) found that 2 in 5 women experienced some form of violence since the age of 15 (39% women, compared to 43% men); 1 in 5 women experienced sexual violence (22% of women, compared to 6.1% men), and 1 in 5 women experienced stalking (20% women, compared to 6.8% men)[4]. Furthermore, larger proportions of women than men experienced all the surveyed forms of intimate partner or family member violence. The largest differences were in physical violence by an intimate partner, a cohabiting partner or a boyfriend, girlfriend or date[1]. The PSS also reported that one in six women and one in nine men experience childhood abuse, and similar proportions witnessed parental violence during childhood[1]. In 2019-2020, there were four times as many women murdered by an intimate partner compared to men[5]. During the period 2017-2021, women were about six times more likely than men to be hospitalised as a result of domestic violence by an intimate partner or spouse[2].

In 2015-16, the cost of violence against women and their children in Australia was $22 billion, with about half of this financial burden ($11.3 billion) borne by victim-survivors[6], almost one-third ($6.5 billion) borne by children of women experiencing violence, perpetrators, employers, friends and family, and the remaining fifth ($4.1 billion) falling to Federal, state and territory governments[7].

General practitioners (GPs) have historically been the first professional contact for survivors of any abuse and violence, and given family, domestic and sexual violence (FDSV) affects people's mental and physical health, GPs need to understand FDSV and how to respond to it[8]. It is estimated that full-time GPs see up to five women per week who have experienced some form of intimate partner abuse (physical, emotional and/or sexual) in the past 12 months[9]. Those affected by FDSV have diverse and complex needs, frequently requiring multiple interventions provided by a range of community-based specialist services. Government and professional recognition of the complexity of these women's needs have acted as a catalyst for integrated responses and all Australian jurisdictions are developing or have developed some type of integrated response to FDSV.

[4] Australian Bureau of Statistics, "Personal Safety, Australia." Available at: https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/2021-22.

[5] Australian Institute for Health and Welfare, "Family, domestic and sexual violence data in Australia" Available at: https://www.aihw.gov.au/reports/family-domestic-and-sexual-violence/family-domestic-sexual-violence-data/contents/about.

6 A broad range of terms are used to refer to people who experience domestic, family and sexual violence. In this evaluation plan we have used the term victim-survivors, in keeping with Commonwealth guidelines.

[7] KPMG, "The Cost of Violence against Women and their Children in Australia: Final Detailed Report" KPMG, Sydney, 2016.

[8] Royal Australian College of General Practitioners, "Abuse and violence: Working with our patients in general practice (4th Ed)" RACGP, Melbourne, 2014.

[9] K. Hegarty, G. McKibbin, M. Hameed , J. Koziol-McLain, G. Feder , L. Tarzia and L. Hooker, "Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis," PLOS ONE, vol. 15, no. 6, p. e0234067, 2020.

Various types of integrated responses to FDSV are used in Australia. The following common elements seemed to have the greatest impact on outcomes[10]:

- Improving the professional knowledge base and service provider relationships
- Increasing cross-program or agency collaboration on case management
- Facilitating responsive and prompt decision-making
- Providing multiple entry points for clients to access support
- Offering a broad range of services beyond the initial crisis period.

Australian Government's response to FDSV

As a result of the burden of harm caused, addressing FDSV has been a priority of the Australian Government for some time, with the first *National Plan to Reduce Violence against Women and their Children* (the National Plan) launched in 2011[11]. This plan aimed to connect the important work being done by all Australian governments, community organisations and individuals to ensure that each year, fewer people experience violence, and more women and children live safely. A key priority of the *Fourth Action Plan* (implemented as part of the overarching National Plan) was improving support and service system responses[12]. Furthermore, in recognition of the lack of evidence in this area, an underpinning principle of the *Fourth Action Plan* was that actions must be evaluated to help build the evidence to understand what works to respond effectively to, and prevent, violence against women and their children[9].

To support implementation of the *Fourth Action Plan*, the Australian Government announced funding totalling $9.6 million (over four years) as part of the 2019-20 Budget. 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 domestic and family violence (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). Each PHN developed and implemented an integrated model tailored to their local needs and service context, building on (but not necessarily replicating) the *RRR* approach. This was known collectively as the DFV Pilot, with activities targeted at 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 focused on the development and delivery of training, resources and capability building activities for primary care staff to enhance their ability 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 positions[13] that acted as conduits between primary care and DFV services with the aim of improving integration and coordination between the primary care and DFV sectors and influencing broader systems change.

[10] J. Breckenridge, S. Rees, K. Valentine and S. Murray, "Meta-evaluation of Existing Interagency Partnerships, Collaboration, Coordination and/or Integrated Interventions and Service Responses to Violence against Women: State of Knowledge Paper," ANROWS, Sydney, 2015.

[11] Council of Australian Governments, "National Plan to Reduce Violence against Women and their Children: Including the First three-year Action Plan," Commonwealth of Australia, Canberra, 2011.

[12] Commonwealth of Australia (Department of Social Services), "Fourth Action Plan: National Plan to Reduce Violence against Women and their Children (2010–2022)," Commonwealth of Australia, Canberra, 2019.

13 System Integrators, the role variously referred to across PHNs as DFV local link(er), connector, navigator or family violence worker.

In early 2023, the Sax Institute completed an independent evaluation of the DFV Pilot[14], finding that it:

- Improved primary care sector awareness, understanding and capabilities in relation to DFV
- Enhanced relationships and collaboration between the primary care and DFV sectors
- Increased primary care sector referrals to DFV support services
- Improved the support experience and outcomes for DFV victim-survivors.

In 2022, the Australian state and territory governments released the second *National Plan to End Violence against Women and Children 2022-2032[15].* This second plan built on the previous plan, highlighting how all parts of society must work together to achieve the shared vision of ending gender-based violence in one generation, including governments, businesses, workplaces, media, educational institutions, the FDSV sector, communities and all individuals. One major new domain in the second *National Plan* is recovery and healing, to which GPs can make a major contribution.

The Australian Government invested an additional $48.7 million in the 2022-23 Budget to expand the scope of the DFV Pilot to cover support for sexual violence (SV), which encompasses child sexual abuse (CSA), and to extend implementation in an additional six PHN regions. This expanded pilot is now referred to as the *Supporting Primary Care Response to Family, Domestic, and Sexual Violence Pilot* (SPC Pilot).

The funding also included $450,000 for the development of nationally consistent sexual violence resources and $800,000 for an independent evaluation of the SPC Pilot.

About the SPC Pilot

The SPC Pilot aims to improve the primary care workforce's ability to recognise and respond to FDSV, increase referrals to specialist services, enhance collaboration between health and support sectors, and ensure equitable, effective support for all victim-survivors.

The SPC Pilot takes a whole-of-practice approach to encourage a climate of disclosure, recognition and response at the practice-level, and allows for flexibility of implementation so that each PHN can tailor an approach that meets their local needs and context. The core components and activities of the SPC Pilot, are:

1. **Capability building**: Delivery of training, resources, and capability-building activities for primary care staff to enhance their ability to recognise and respond to FDSV
2. **System Integration**: Having a dedicated System Integrator who acts as a conduit between the primary care workforce and specialist FDSV service staff
3. **Influencing the system for sustainable change:** Influencing broader systems change by ensuring key system stakeholders can come together (e.g., via Communities of Practice or networking events) to jointly work on overcoming systemic barriers to change.

While the primary care workforce remains a key focus, the SPC Pilot also aims to engage Aboriginal health services, allied health services, mental health services, community health services, and in some sites, pharmacists and dentists.

[14] S. Newell, S. Rose, A. Knight, S. Nepal, C. Crook and P. Ninnes, "Evaluation of the Improving Health System Responses to Family and Domestic Violence Primary Health Network Pilot: Final Report," Sax Institute, Sydney, 2023.

[15] Australian Government. "The National Plan to End Violence against Women and Children 2022–2032". Available at: https://www.dss.gov.au/national-plan-end-gender-based-violence/resource/national-plan-end-violence-against-women-and-children-2022-2032

Key stakeholders involved in the SPC Pilot

Primary care workforce: Health practitioners, including general practitioners (GPs), practice nurses, allied health professionals, administrative staff (including practice managers, receptionists and other practice support staff) who interact with, or care for, victim-survivors in their day-today roles.

System Integrator: An individual, typically employed by a specialist FDSV service or other suitable organisation (e.g., Local Health Network or Aboriginal Medical Service), with expertise in the area of FDSV, whose role is to improve integration, coordination and referrals to and between primary care and specialist FDSV services. System Integrators are variously referred to as Linkers, Local Links, Connectors or Navigators across PHNs.[16]

Specialist FDSV service: Services that engage directly with victim-survivors, perpetrators and families when FDSV has occurred.

Primary Health Network (PHN): PHNs are independent organisations funded by the Australian Government to coordinate primary care locally and commission services where there are healthcare gaps. PHNs play a key system integration role in the SPC Pilot, connecting various levels of government, and enabling important system-level changes to enhance implementation and impact of Pilot activities.

As summarised below, the SPC Pilot supports 12 PHN regions; 11 (through consortium arrangements) now support a Pilot for FDSV and CSA and one PHN (North Western Melbourne PHN) supports a Pilot for FDV only.

Established PHNs

- Brisbane South PHN (BSPHN)
- Central and Eastern Sydney PHN (CESPHN)
- Hunter New England and Central Coast PHN (HNECCPHN)
- Nepean Blue Mountains PHN (NBMPHN)
- North Western Melbourne PHN (NWMPHN)
- Western Victoria PHN (WVPHN)

New PHNs

- Adelaide PHN, in consortium with Country South Australia PHN (SAPHN Consortium)
- Australian Capital Territory PHN (ACTPHN)
- Northern Territory PHN (NTPHN)
- Tasmania PHN (TASPHN)
- Western Australia Primary Health Alliance (WAPHA), responsible for delivery of the Pilot in Perth South PHN

At the time of writing, five of the 12 PHN regions were in the early stages of implementation of the SPC Pilot, and another five were in the early stages of implementing the SV and CSA components but were well advanced in their implementation of the FDV components.

[16] All but one PHN (NWMPHN) adopted this model of commissioning a specialist FDSV service who employed a System Integrator. NWMPHN instead commissioned experts from the University of Melbourne to support this aspect of their model.

The SPC Pilot seeks to achieve the following outcomes:

- Improving primary care workforce awareness, ability and confidence to recognise and respond to FDSV
- Increasing primary care referrals to specialist FDSV support services
- Improving specialist FDSV support services' understanding of the role of primary care in supporting victims-survivors
- Improving relationships and collaboration between the primary care and FDSV sectors towards a more coordinated approach to supporting victims-survivors
- Equitably improving all FDSV victim-survivors' experiences and outcomes of receiving support.

The program logic (Appendix 1) summarises how the SPC Pilot intends to influence outcomes for the three target groups: 1) Primary care workforce; 2) Specialist FDSV support services; and 3) FDSV victim-survivors. It also demonstrates that while there will be variations in how the SPC Pilot is implemented in each PHN, there is consistency in the core problems they are trying to resolve (Situation column) and the outcomes they are seeking to influence (Outcomes column).

Interim evaluation approach

Scope

This interim evaluation reports findings relating to component 1 (capability building) and component 2 (system integration activities), but not component 3 (system influencing activities) of the SPC Pilot. The final evaluation report (due early 2027) will include findings related to all components of the SPC Pilot. The final evaluation report will also include a more comprehensive analysis of outcomes, including for victim-survivors, and report on how the different models implemented by each PHN may, or may not have, impacted outcomes achieved at the primary care, specialist FDSV service, and victim-survivor levels.

Aims

This interim report provides initial findings of the evaluation and aims to:

1. To describe the training, resources, capability building supports, and system integration activities implemented in each PHN (activities of components 1 and 2), and levels of participation in, or engagement with, these activities
2. To understand perceptions of SPC Pilot activities, specifically in relation to acceptability, experience, and any perceived enablers or barriers to implementation or participation
3. To explore early outcomes achieved at the primary care level in relation to their ability recognise and respond to FDSV
4. To identify preliminary insights and recommendations.

To support the evaluation to collect data to answer these aims, in collaboration with participating PHNs and the DHDA, we developed a nuanced set of Key Evaluation Questions (KEQs) and sub-questions. These KEQs and sub-questions, and how they relate to each aim, are summarised in Appendix 2.

Methods

This interim evaluation used a mixed methods design incorporating various quantitative and qualitative data sources. Analyses from the various data sources were concurrently triangulated to validate each other and produce overarching findings in relation to the evaluation aims.

Quantitative data sources

CRM and Excel Tracker monitoring data

A Customer Relationship Management (CRM) system was developed in partnership with Infoxchange to better enable PHN staff and their commissioned System Integrators to track and manage their interactions with the primary care workforce. The data collected in the CRM is similar to, and builds on, the data collected via the Excel Trackers in the previous DFV Pilot evaluation. The use of the CRM by PHNs was not mandatory and four PHNs (and their commissioned System Integrators) opted

to remain collecting monitoring data via the Excel Tracker. Table 1 shows the CRM and Excel Tracker data that was available from the participating PHNs for this analysis and reporting. Implementation data was available for 9 of the 12 participating regions, with the SAPHN Consortium and TASPHN close to starting to collect the data.

Table 1: CRM and Excel Tracker data available for analysis

PHN	OLD Excel Trackers	NEW Excel Trackers	CRM data
ACTPHN			Feb25-Apr25
BSPHN	Apr-Jun24		Jul24-Apr25
CESPHN	Jan-Jun24		Jul24-Apr25
HNECCPHN	July22-Jun24		Jul24-Apr25
NBMPHN	Jan23-May24	Jun24-Apr25	
NTPHN		Jul24- Apr25	
NWMPHN	Nov23-Feb25	Mar25- Apr25	
SAPHN Consortium			
TASPHN			
WAPHNs			May24-Apr25
WVPHN			Jun24-Apr25

Both the CRM and Excel Trackers allow collection of the following information:

- **Training and resources for primary care staff**, including details on the type of training delivered, and the number of individuals in attendance which will be stratified by occupation.
- **Engagement with primary care staff**, including the type of engagement, number, duration and mode of contact by the System Integrator with primary care practices (including whether referrals or referral recommendations were made as part of the engagement).
- **Referrals** from primary care staff to System Integrators.
- **Support** provided to those referred clients (including onward referrals to external services for additional support).
- **Practice characteristics** such as the location (PHN and Local Government Area).

Data from the CRM and the Excel trackers were merged and analysed to understand the level of participation of primary care staff in SPC Pilot activities in each PHN region between July 2022 and April 2025, including the characteristics of participating staff and primary care practices (e.g., age, gender, profession, type of practice, years in practice, Aboriginal and Torres Strait Islander status, and CALD background).

Episodic Survey (baseline and follow-up)

Baseline and follow-up episodic surveys were developed to capture data about the extent to which the SPC Pilot activities increased the ability of primary care staff to recognise and respond to FDSV and refer to specialist FSDV services when appropriate. The surveys captured data between the period 1 July 2022 to 30 April 2025.

The surveys (Appendices 3-4) were administered electronically using Qualtrics. They captured basic demographic information and self-reported outcome data to understand participants level of

awareness and knowledge of FDSV and their confidence and ability to recognise and respond to FDSV. Participants were invited to complete the baseline survey when they first engaged with the SPC Pilot activities (for example, attending a training session or receiving guidance from a System Integrator) and approximately six months later. SAPHN Consortium and TASPHN were not included in the analysis as they had not implemented SPC Pilot activities at the time this interim evaluation report was being prepared. As shown in Table 2, a total of 824 baseline surveys and 148 follow-up surveys were completed, with varying numbers of responses to the different survey questions. WVPHN had the highest number of baseline survey responses, comprising 33% of all baseline survey responses (n=270 of 824 responses), followed by CESPHN (21%, n=171 of 824). NWMPHN had the highest number of follow-up survey responses, comprising 34% of all follow-up survey responses (n=50 of 148 responses), followed by CESPHN (23%, n=34 of 148). Both the baseline and follow-up surveys were completed mostly by health practitioner (66% of all baseline survey responses and 60% of all follow-up survey responses) and most of the survey respondents worked in GP practices that had at least two GPs employed.

Table 2: Baseline and follow-up survey response numbers and characteristics

Category	Characteristic	Baseline – Number of responses	Baseline – % total responses	Follow-up – Number of responses	Follow-up – % total responses
PHN	ACTPHN	97	11.7%	0	0.0%
PHN	BSPHN	14	1.7%	1	0.7%
PHN	CESPHN	171	20.7%	34	23.0%
PHN	HNECCPHN	61	7.4%	12	8.1%
PHN	NBMPHN	82	9.9%	29	19.6%
PHN	NTPHN	1	0.1%	0	0.0%
PHN	NWMPHN	100	12.1%	50	33.8%
PHN	WAPHA	31	3.7%	0	0.0%
PHN	WVPHN	270	32.6%	22	14.9%
Professional role	Health practitioner	542	65.5%	88	59.5%
Professional role	Practice manager	95	11.5%	27	18.2%
Professional role	Administrative staff	190	23.0%	33	22.3%
Practice type	Multi-GP practice (2-5 GPs)	123	14.9%	29	19.6%
Practice type	Multi-GP practice (6-10 GPs)	175	21.2%	48	32.4%

Category	Characteristic	Baseline – Number of responses	Baseline – % total responses	Follow-up – Number of responses	Follow-up – % total responses
Practice type	Multi-GP practice (11+ GPs)	102	12.3%	11	7.4%
Practice type	Solo GP practice	10	1.2%	3	2.0%
Practice type	Other medical practice	269	32.5%	18	12.2%
Practice type	Allied health service	37	4.5%	10	6.8%
Practice type	Aboriginal Medical Service	15	1.8%	3	2.0%
Practice type	Other ACCHO	1	0.1%	0	0.0%
Practice type	Dental service	0	0.0%	0	0.0%
Practice type	Local Health District	17	2.1%	1	0.7%
Practice type	Pharmacy	1	0.1%	1	0.7%
Practice type	Psychology service	46	5.6%	11	7.4%
Practice type	Community-based support service	11	1.3%	5	3.4%
Practice type	Sexual health centre	9	1.1%	5	3.4%
Practice type	Other	11	1.3%	3	2.0%
Total	-	827	100%	148	100%

Baseline and follow-up survey data were cleaned and analysed using Stata 18 statistical software. Descriptive counts and proportions were calculated for all survey items overall (i.e., aggregated across all 12 PHN regions) and, where relevant, by PHN. Open-ended survey questions were analysed thematically and aggregated across all PHNs using Microsoft Excel. Mean scores and standard deviations (SD) were generated for rating scale items and independent t-tests performed to assess any differences in means between baseline and follow-up survey data.

Qualitative data sources

Interviews were conducted with PHN staff, System Integrators, health practitioners (GPs and other allied health professionals, inclusive of nurses, physiotherapists, psychologists and occupational therapists), and administrative staff (receptionists and practice staff of GP clinics). Interviewees were identified by the project managers and leads from each of the 12 PHN regions, then contacted by the research team to inform them of the purpose of the evaluation, schedule an interview, and obtain

participant consent. GPs and other health practitioners who operated as a private practice and for whom participation in the interview would result in a loss of income, were reimbursed $150 to compensate them for their time.

Interviews were conducted between between February and June 2025 and lasted between 20 and 60 minutes. An interview guide (Appendix 5) was developed by the evaluation team and adapted for PHN staff/System Integrators, health practitioners and admin staff. All interviews were conducted, recorded (with participants' consent) and transcribed via Microsoft Teams. Interviews were systematically analysed using Microsoft Excel, using a coding framework developed by the evaluation team which was informed by the discussion guide. Two members of the evaluation team independently coded a sample of transcripts to identify and refine the emerging themes and sub-themes in relation to the interim evaluation aims.

Table 3 provides a breakdown of participation in the interviews by PHN. In total, 80 individuals were interviewed in either a group interview (n=38) or one-on-one (n=42), consisting of 44 System Integrators, 22 PHN staff, 11 health practitioners and 3 admin staff across all PHNs.

Table 3: Qualitative interview participants, by PHN and role in the SPC Pilot

PHN	PHN staff	System Integrators	Health practitioners	Administrative staff	Total
ACTPHN	1	4	1	0	**6**
BSPHN	2	7	2	0	**11**
CESPHN	2	2	3	0	**7**
HNECCPHN	3	7	0	0	**10**
NBMPHN	2	5	3	2	**12**
NTPHN	1	5	0	0	**6**
NWMPHN	2	0	2	1	**5**
SAPHN Consortium	3	8	0	0	**11**
TASPHN	2	0	0	0	**2**
WAPHA	2	3	0	0	**5**
WVPHN	2	3	0	0	**5**
Total	**22**	**44**	**11**	**3**	**80**

Methodological limitations

Quantitative evaluation

The nature of the SPC Pilot meant that using experimental evaluation methods would not have been ethical or feasible, making it difficult to accurately attribute the extent to which any outcome changes are the result of the SPC Pilot. With such a complex initiative over a seven-year implementation period, a wide variety of factors outside the SPC Pilot may also have an impact on the outcomes of interest. In addition, participating PHNs are at varying levels of readiness to implement the full range of SPC Pilot activities, including the PHNs that were involved in the previous DFV pilot. There is also variation in the SPC Pilot implementation activities being delivered in each PHN and in levels of

primary care engagement with those activities. This means that each PHN may achieve a different implementation intensity, which will likely have an impact on the outcomes achieved.

As at 30 June 2025, there were six PHNs utilising the CRM and four PHNs using Excel monitoring trackers to monitor, record and update their engagements with GPs and practice staff, as well as trainings, quality insurance and referral processes and outcomes. The flexibility for PHNs to adopt either data collection approach introduced an additional layer of complexity when collating and cleaning the datasets from both sources to be able to conduct meaningful and standardised analyses across all participating PHNs. Furthermore, there was also variability in how participants entered details relating to practice characteristics (e.g., some PHNs documented all the practices in their region or district while others only specified the number and details of practices who explicitly engaged in the SPC Pilot), as well as how they perceived interactions with practices to be 'meaningful'. The recent amendments made to the CRM between March and May 2025 also meant that the system functionality to conduct high-level reporting (contact reports) was offline during this period. As a result, some PHNs utilising the CRM opted to revert back to using the Excel monitoring tracker for this duration. Finally, two of the 12 PHNs (WVPHN and NWMPHN) have been using surveys that are delivered by their university or service partners; the outputs of these surveys had to thus be integrated with the broader survey data utilised by all other participating PHNs when analysing this information for this current evaluation.

Qualitative evaluation

Although the semi-structured interviews provided a wealth of information regarding stakeholder perceptions of the development and delivery of the SPC Pilot, the process itself was constrained by several methodological factors. For one, it was expected that up to 10 stakeholders from each of the 11 participating PHNs would engage in semi-structured interviews. This quota, however, was not met across most PHNs, and participant representation in general was higher among established PHNs, relative to new PHNs. Similarly, there were several questions pertaining to training, system integration, and participant and service-level outcomes that could not be fully answered by interviewees who were new to the SPC Pilot, or who had yet to engage in some of these processes which prevented in-depth analysis of interview themes that were standardised and consistent across each of the participating PHNs. It is anticipated that all PHNs will be more advanced in their implementation in the next phase of the evaluation. This will provide greater opportunities for standardised and consistent analysis

Finally, relative to System Integrators and PHN staff, health practitioners and administrative staff were harder to recruit and therefore under-represented in the interview data. These findings should be interpreted with caution.

Implementation findings

From 1 July 2022 to 30 April 2025, the 12 participating PHN regions delivered a total of 721 training sessions to 3,751 attendees, with training reaching a broad cross-section of the primary care workforce. The majority of the attendees worked at medical practices, mostly practices with 2-5 GPs or more than 11 GPs. Concurrently, a total of 8,446 meaningful interactions between System Integrators and primary care staff across 1,124 practices during which the System Integrators aimed to build capability in practices were recorded. Participating PHNs also sought to strengthen system integration via formal partnerships, inter-agency forums, and development of referral pathways to specialist services.

Training

Description of training delivered across PHNs

All PHNs implemented a training package that focused on building the ability of primary care staff to respond to FDSV, such as *Recognise, Respond, Refer*, *Pathways to Safety*, *or DFSV Fundamentals*, and several developed or commissioned bespoke training modules to address specific topics. BSPHN offered sessions on coercive control, non-fatal strangulation, and DFV in the context of culture and identity, with tailored content for First Nations communities, CALD communities, LGBTQIA+ individuals, and people with disabilities. CESPHN delivered weekly training on responding to DFV, SV and CSA in partnership with Legal Aid NSW and local health districts, while HNECCPHN provided on-demand training on DFV Levels 1 and 2, CSA, and applied practice sessions. DFV Level 1 outlines foundational DFV concepts (e.g., Spot the Signs & Start the Conversation), whereas DFV Level 2 focuses on case studies and action plans to identify and address the risks reported by DFV victim survivors. NBMPHN extended its training to medical students and planned a “Next Steps” module to follow its introductory DFV training. WVPHN co-developed and designed Wanga Laka training and is currently delivering this training package to a range of ACCHOs since May 2025.

Training was typically delivered online or in hybrid formats, with some PHNs offering modular or on-demand options to accommodate practice schedules and provide flexibility in how practices could access training. While uptake was generally strong, PHNs in rural and remote areas, such as NTPHN and WAPHA, noted challenges in maintaining engagement due to high workforce turnover. Further information on the specific types of training delivered across PHNs can be found in Appendix 6. Please note: SAPHN Consortium and TASPHN had not commenced delivery at the time of this interim reporting.

Volume of training delivered by practice type and PHN

Between July 2022 and April 2025, a total of 721 FDSV training sessions were delivered across nine of the PHN regions (all but SAPHN Consortium and TASPHN). As shown in Table 4, delivery scale varied substantially, with BSPHN delivering the highest number of training sessions (n=161 of 721) but HNECCPHN delivering training to the highest number of participants (n=1,041 of 3,751). The ‘Recognise, Respond, Refer’ training was delivered most frequently, comprising 16% (n=118 of 721)

of all training sessions, and was the most attended, with 17% (n=650 of 3,751) individuals engaging in this training during the SPC Pilot period.

Table 4: Numbers of training sessions delivered and training attendees, by PHN (July 2022 to April 2025)

PHN	Number of training sessions	Total number of training attendees*
ACTPHN	5	31
BSPHN	161	797
CESPHN	144	498
HNECCPHN	127	1,041
NBMPHN	113	452
NTPHN	30	166
NWMPHN	66	220
WAPHA	8	63
WVPHN	67	483
Total	**721**	**3,751**

* Some individuals may have attended multiple training sessions

** Note that training sessions delivered by WVPHN as part of the Wanga Laka First Nations Project is not included in the CRM data provided. Quantitative and qualitative data for delivery of this training with ACCOs in the WVPHN region sits outside this Interim Report.

As shown in Table 5, over two-thirds of all training sessions were delivered in primary care practices that had at least two GPs (70%, n=508 of 721), with 33% of training sessions (n=240 of 721) delivered in practices employing between 2-5 GPs, 19% (n=138 of 721) of training sessions delivered in practices employing 6-10 GPs, and 18% (n=130 of 721) of training sessions delivered in practices employing 11 or more GPs. Fewer instances of training were delivered in single GP practices (3%, n=23 of 721). Training was also delivered in non-primary care practices, with 7% (n=53 of 721) of training sessions delivered in allied health services, 5% (n=37 of 721) in an Aboriginal Medical Service (AMS) or Aboriginal Community Controlled Health Organisation (ACCHO), 1% (n=6 of 721) delivered in community organisations, 1% (n=4 of 721) in a psychology service, and 11% (n=82 of 721) delivered in other settings which included universities, aged care services, medical specialists and LHDs.

The majority of training sessions were delivered to a practice or service in the six established PHNs: Around a fifth (22%) of training sessions were delivered in BSPHN (n=161 of 721), 20% (n=144 of 721) in CESPHN, 18% (n=127 of 721) in HNECCPHN, 16% (n=113 of 721) in NBMPHN, 9% (n=67 of 721) in WVPHN, and 9% (n=66 of 721) in NWMPHN. The newly established sites of NTPHN, WAPHA, and ACTPHN delivered 4% (n=30 of 721), 1% (n=8 of 721) and 1% (n=5 of 721) training sessions, respectively. The amount of training that was delivered varied across PHNs by practice or service type. For example, CESPHN delivered 29 training sessions to allied health services, accounting for more than half (55%, n=29 of 53) of all instances of training delivered to allied health services. Of the 37 instances of training delivered to an AMS or ACCHO, 83% of these were delivered to an AMS or ACCHO in the BSPHN (n=16 of 37) and NTPHN (n=15 of 37) regions.

Table 5: Number of training sessions delivered, by practice type and PHN (July 2022 to April 2025)

PHN	Multi-GP (2-5)	Multi-GP (6-10)	Multi-GP (11+)	Solo GP	GP (size unknown)	Allied health service	Community service	Psychology service	AMS & ACCHO	Other	Total
ACTPHN	3	1	1	0	0	0	0	0	0	0	**5**
BSPHN	69	49	12	5	8	0	0	0	16	2	**161**
CESPHN	26	23	37	7	0	29	1	4	0	17	**144**
HNECCPHN	32	20	14	4	0	4	2	0	3	48	**127**
NBMPHN	39	28	25	4	0	11	0	0	0	5	**113**
NTPHN	0	0	0	0	0	9	3	0	15	3	**30**
NWMPHN	27	12	17	3	0	0	0	0	3	4	**66**
WAPHA	4	4	0	0	0	0	0	0	0	0	**8**
WVPHN	40	1	24	0	0	0	0	0	0	2	**67**
Total	**240**	**138**	**130**	**23**	**8**	**53**	**6**	**4**	**37**	**82**	**764**

Participation in training activities

By practice type and PHN

Most of the 3,751 participants that attended a training session between July 2022 and April 2025 worked at a general practice (63%, n=2,347 of 3,751), with 26% of participants from practices employing 2-5 GPs (n=968 of 3,751) (see Table 6). Participants working in general practices with only one GP employed appeared to be less likely to attend the training (1%, n=41 of 3,751). Of the participants that worked in other parts of the primary care sector (i.e. not general practice), 4% (n=133 of 3,751) worked in an allied health service, 7% (n=281 of 3,751) in an AMS or ACCHO, 0.2% (n=9 of 3,751) in a community service, and 0.2% (n=6 of 3,751) in a psychology service.

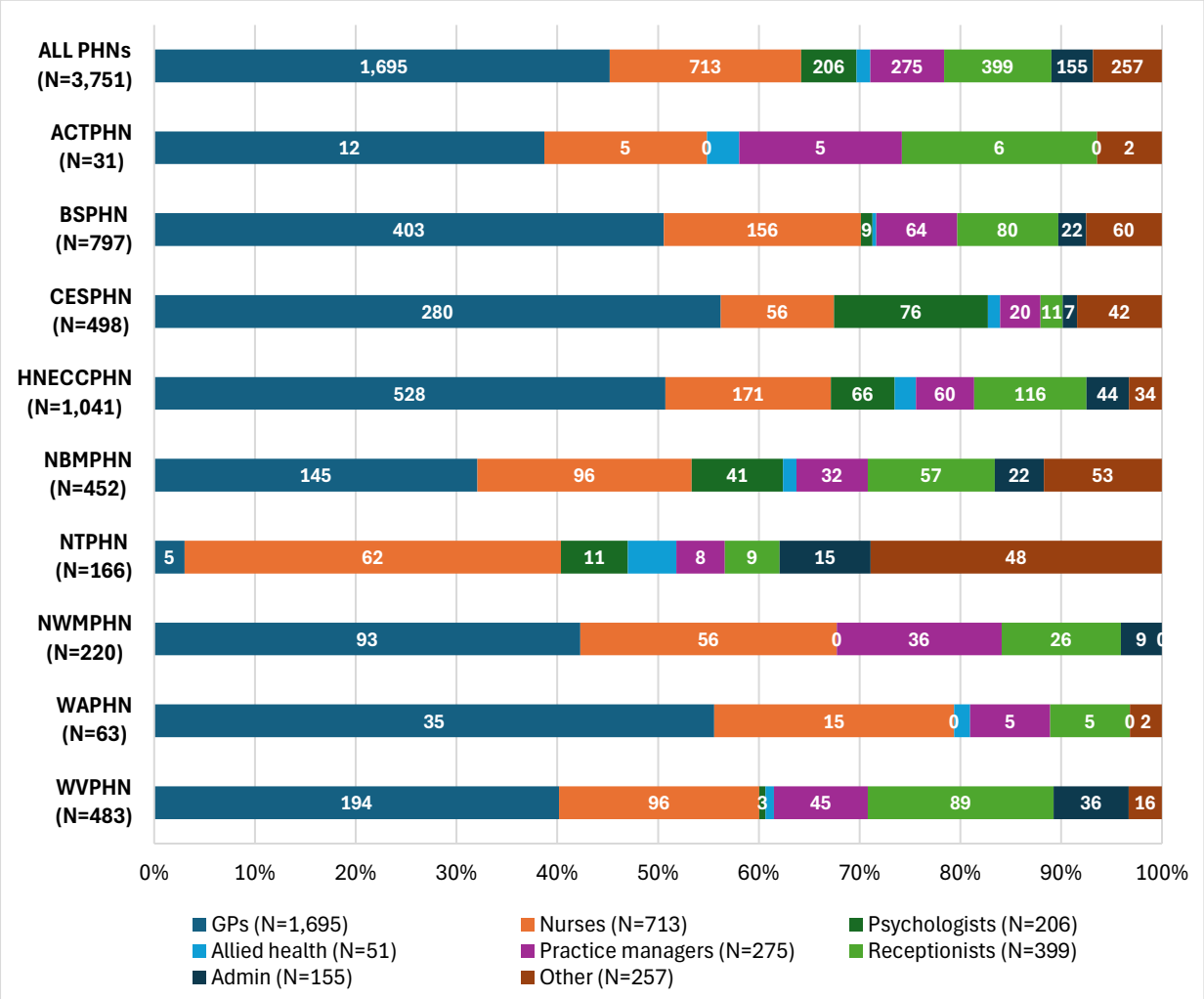
Table 6: Number of participants at training sessions by practice type (July 2022 to April 2025)

PHN	Multi-GP (2-5)	Multi-GP (6-10)	Multi-GP (11+)	Solo GP	GP (size unknown)	Allied health service	Community service	Psychology service	AMS & ACCHO	Other	Total
ACTPHN	12	6	13	0	0	0	0	0	0	0	**31**
BSPHN	290	244	91	17	26	0	0	0	118	11	**797**
CESPHN	68	63	124	7	0	78	1	6	0	151	**498**
HNECCPHN	117	122	117	6	0	7	2	0	6	664	**1,041**
NBMPHN	144	106	107	6	0	37	0	0	0	52	**452**
NTPHN	0	0	0	0	0	11	6	0	149	0	**166**
NWMPHN	90	45	54	5	0	0	0	0	8	18	**220**
WAPHA	34	29	0	0	0	0	0	0	0	0	**63**
WVPHN	213	3	255	0	0	0	0	0	0	12	**483**
Total	**968**	**618**	**761**	**41**	**26**	**133**	**9**	**6**	**281**	**908**	**3,751**

By staff type and PHN

PHN CRM and Excel tracker data indicated that a wide range of professionals engaged with the SPC Pilot training, which was usually delivered to multiple staff within primary care practices (see Figure 1). Of the 3,751 participants, GPs were the largest participant group, comprising 45% of all participants across the nine PHNs between July 2022 and April 2025 (n=1,695 of 3,751), followed by practice nurses (19%; n=713 of 3,751), receptionists (11%; n=399 of 3,751), practice managers (7%; n=275 of 3,751), psychologists (5%; n=206 of 3,751), administrative staff (4%; n=155 of 3,751), and allied health professionals (1%; n=51 of 3,751).

Figure 1: Training attendance by staff type and PHN (July 2022 to April 2025)



Stakeholder perspectives

Overall, interviewees reported that the training they had received was informative and beneficial, and that it had **improved their knowledge about, and confidence to, recognise and respond to FDSV**. They felt that training was acceptable and of value, especially when it was delivered flexibly, had practical value, and was linked to Continuing Professional Development (CPD) points.

"Yeah, I wouldn't change anything, just more of it and making sure that people have the opportunity to access it. I really think it should be given to as many people as possible." (Psychologist)

"Oh, I feel much more confident since I've done the FDSV course that we had last year. It really was very good. Quite an eye opener because there were times I didn't know what to say and how to begin the conversation, and how to, you know, make the patient reassured that I'm not digging into their lives." (GP)

Interestingly, no interviewees mentioned that it is possible for the training to contribute to CPD points for Nursing and Midwifery Board of Australia (NMBA) registration, or re-registration.

Feedback from survey respondents also described how the training had enabled them to recognise signs of coercive control (e.g., bruises, body language), use appropriate language, ask about FDSV at the right time, and incorporate FDSV screening into their routine consultations and assessments.

What worked well?

Flexibility of delivery

The importance of being flexible about when and how training was delivered and meeting GPs "on their turf" so they did not feel like they were sacrificing clinical time, was a consistent theme among interviewees. Strategies such as delivering training on weekends or afterhours, to align with the busy schedules of GPs, or delivering the training at venues near GP practices (e.g., local parks or community centres), were perceived as an important enabler for increasing GP participation in training. Additionally, interviewees talked about the importance of offering modular training that reduced their overall time commitment and helped them at least "start" the training, even when they were very busy. Online training was also thought to be an important mechanism for improving GP participation in the training, although some interviewees raised concerns about the difficulty of identifying and responding to the signs of emotional and psychological distress during online training sessions.

"So, we have delivered lunch times, evenings, mornings in a park... There were 4 GPs booked for the session and they were having lunch and they called us over, so we got the laptop out and did the training in the park, so we really meet the GPs where they're at." (PHN staff member)

"Having that engagement of being so adaptive, with online training available, able to fit different time slots for GPs definitely makes it more suitable for them to come in and utilise the service." (System Integrator)

Practical guidance and real-life examples

Interviewees indicated that engagement and participation in training improved when the content mirrored real-life consultations and when there was clear, step-by-step guidance on 'what to ask', 'how to ask it', 'how to document', and 'what to do next'. Short, memorable prompts reduced anxiety about "saying the wrong thing," and role-plays/case scenarios helped staff rehearse and feel better prepared.

"I think what really worked was they had these phrases that we had to say so that, you know, to validate their feelings and make them feel you believe in what you say and you're listening, and you're here to help and give them what they need." (GP)

"Honestly, I found it overall very informative… having somebody come out and provide case studies and scenarios like that was very great and it definitely helped me in my day-to-day being able to recognise DFV in normal day-to-day scenarios." (Admin staff)

Interviewees shared that focused modules on sexual choking and non-fatal strangulation, often taught through case studies or role-play, were especially informative and very well attended. Many participants had either never heard of these topics or had a minimal understanding but desired further information.

“I remember just thinking I wanted like 10 more hours of it [training]….we learned some really important facts that we can now use with our clients as well. I mean, even just the knowledge that strangulation can lead to death, and that even that even if the person doesn't pass out it and doesn't show symptoms, that still should be treated as a very serious medical event for treatment. Even little things like that" (Psychologist)

"The information around the strangulation stuff was interesting to me. I didn't really know too much about that being a precursor to more serious harm." (GP)

A whole-of-practice approach to training

One of the strongest themes to emerge from interviews was the importance of delivering a whole-of-practice approach to training. Interviewees felt that allowing both clinical and non-clinical staff to attend FDSV training ensured there was a level of synergy among everyone in the practice who interacted with victim-survivors (and perpetrators) of FDSV – from GPs who diagnose and manage symptoms relating to FDSV, to receptionists who first make contact with patients and identify signs of possible FDSV.

"I think it's had quite a significant impact on the practice. Frontline reception staff are now able to better recognise patients experiencing the FDSV and know how to approach that in a sensitive way that makes them feel as comfortable as possible.” (Admin staff)

“Clinical staff are also more knowledgeable about how to appropriately and where to appropriately refer patients and how and I feel personally, I know I've got a lot more confidence in how to handle that situation myself as well." (Admin staff)

Survey respondents also indicated that the whole-of-staff approach to training had been critical for fostering culture change across the practice, and enabled all staff, whether clinical or non-clinical, to feel empowered and equipped to recognise and respond to FDSV in their workplace.

Tailoring for local context and co-facilitation

Another common theme was the importance of tailoring training to different priority population groups, and working with these groups to co-design training content, to ensure that it is fit-for-purpose, culturally safe, accessible and meaningful. In NTPHN, for example, animations that include First Nations people and communities have been developed to convey culturally relevant messaging and information about FDSV.

"And even when we've worked with our workforce advisory group and sort of been doing codesign [of the training] with them, something that often comes up is things have been designed elsewhere and then applied to the NT context and they don't often land, and they really need to feel that it's come from the NT and being made for the NT for it to work." (System Integrator)

Interviewees highly valued co-facilitation of training with System Integrators, and where appropriate, victim-survivors, as they had more confidence that it was relevant to their local context and needs. Additionally, staff were more willing to attend when facilitators were from the local area and could

speak to real-world processes (e.g., what to do when subpoenaed, what are the local referral options) relevant to their jurisdiction.

What could be improved?

Formal recognition and remuneration for participation

Across PHNs, interviewees noted that the strongest barrier to GP participation in training continues to be the time commitment and financial impact of participation. They suggested that GPs need dedicated and protected time (or adequate remuneration/incentives) to attend training sessions because interest rarely translated into attendance. There was a sense that it was not financially or logistically feasible for clinics to close their doors for one to two hours for training, particularly if there were multiple trainings that would need to be conducted in the future, because "if they stop work for training, they lose money". There were also suggestions that to improve GP participation, training needs to be planned well in advance and delivered in shorter blocks (i.e., less than two hours per session).

Interviewees described CPD points being linked to training participation as a strong enabler of participation, particularly for GPs. One GP interviewee referred to the linking of CPD points to training participation as a "carrot" and indicated that it was a motivating factor that encouraged GPs to "release their time", especially as they were always so busy.

"I think there's a bit of a mixed response [to primary carer's ability to recognise and respond to FDSV] in the sense that it's really dependent on the GP and the practice...There are a lot more GPs attending the GP education session when they are planned well and truly in advance of time. And when there's a lot of notice and which is good" (PHN staff member)

"The only challenge we have is I could not engage more doctors. So, if there is something in regards to engaging more doctors, maybe it could be CPD points, incentives, or something because doctors are so busy... they do ask me that question, 'what's in it for them?'" (GP)

GP hesitancy

Another persistent barrier was hesitancy among some GPs to engage with training focused on sexual violence and child sexual abuse. Participants described a mixture of discomfort discussing these topics, uncertainty about how to respond to disclosures, and a sense that the sessions did not always "land" with GP priorities or clinic culture which led to lower interest or selective attendance. This reluctance was linked to stigma and shame in the broader community that can spill into clinical settings, and to a perceived need for clearer, more standardised CSA content and referral pathways to build confidence.

"This is very new to them and there is hesitancy around talking about it and responding to it." (System Integrator)

"Some practices are extremely resistant to the whole concept of DV and have refused training on matter of principle. How do you then manage this when GPs aren't trained in DV? What does this mean for accreditation, such as in organisations with lawyers hampering access to GPs?" (System Integrator)

Training content

Interviewees from some PHNs felt parts of the training were too theoretical and “quite didactic”. They would have liked more practical examples, particularly related to procedures involving police and other legal personnel. There was also a consistent theme amongst non-clinical interviewees that the training they received could have incorporated more of the specific information provided in the clinical sessions.

"Sometimes we get feedback on a training saying you didn't really need to talk too much about the definition of what it is like…we would have preferred to go more into the practical side of things" (PHN staff member)

“I did find that at least the non-clinical training was mostly just sort of definitions and theory… it did feel a bit surface level. So, I would have liked to see a bit more non -clinical depth to that" (Admin staff)

One occupational therapist interviewee felt the training skewed too much toward general practice and did not translate as well to elder-abuse contexts or carer scenarios.

“Training is a little too specific and tailored for GPs and their practices… I really don’t feel like I can support the carer… I don’t feel overly confident.” (Occupational Therapist)

According to some interviewees, some training packages could have had more of a focus on coercive control and female-to-male violence. Some also noted that more training content was required to improve participant understanding and awareness of mandatory reporting for child sexual abuse or other forms of violence.

"I'd say probably there's still some versions of DV that are more subtle and therefore a little bit harder for people to identify. Also, I know it hasn't necessarily been the focus of our training, but when it's kind of female to male violence, I think that's harder for people to kind of get a sense of as well." (Psychologist)

"There's certainly been interest around the sexual violence in childhood sexual abuse and certainly the childhood sexual abuse probably pulls on heartstrings a little bit. And it's also because they have the mandatory reporting requirements. I'm surprised at how often they still hesitate and don't understand what those requirements are." (System Integrator)

Resources

Description of resources that PHNs provided

PHNs developed a wide range of resources to support clinical practice and patient engagement. These included action plans, referral directories, flowcharts, pocket guides, posters, and multimedia materials. Many resources were co-designed with local DFV, SV and CSA services and tailored to specific audiences. For example, ACTPHN developed 33 resources, including National Centre tools, RACGP materials, and role-play videos co-produced with Canberra Rape Crisis Centre (CRCC), Domestic Violence Crisis Service (DVCS) and Newcast Media. CESPHN produced over a dozen resources, including coercive control posters, DV model diagrams, and subpoena survival guides, many of which they distributed to over 50 practices.

Several PHNs embedded clinical tools into HealthPathways[17] to support real-time decision-making. NTPHN integrated National Centre practice tools into HealthPathways and developed a video resource for working with survivors of SV and CSA. NWMPHN created a dedicated HealthPathways page on domestic violence and distributed supporting materials such as a clinical audit spreadsheet, e-learning modules, and participant handbooks.

Resources were also developed to support culturally safe care. SAPHN Consortium produced visual tools and practice guidelines tailored to remote communities and CALD populations. TASPHN created scripts and presentations for Aboriginal Health Services based on the Spot the Signs, Ask the Questions, Validate and Believe, Assess the Risk, Document and Act on Referrals (SAVADA) model, while WAPHA developed a WA-specific version of the Common Risk Assessment and Risk Management Framework (CRARMF) and materials for LGBTQIA+ patients. Distribution varied, with some PHNs reporting dissemination to hundreds or thousands of recipients, while others were still piloting or refining materials.

Number and type of resources provided by PHN

Between July 2022 and April 2025, 2,974 interactions between System Integrators and practices that involved resource provision (e.g., circulating FDSV related info or flyers) were recorded across all PHNs. A total of 7,238 resources were distributed by the System Integrators during these interactions (including multiple copies of most resources), with an average of 2.4 resources provided per interaction. Table 7 provides an overview of the resources provided by the System Integrators across the PHN (see Appendix 7 for more detailed information).

Table 7: Resource distribution by PHN (July 2022 to April 2025)

PHN	Number of interactions between System Integrators and practices during which resource(s) were provided	Total number of resources provided
ACTPHN	38	797
BSPHN	1,246	1,564
CESPHN	205	1,008
HNECCPHN	1,138	3,210
NBMPHN	220	255
NTPHN	11	114
NWMPHN	68	112
WAPHA	5	10
WVPHN	43	168
All PHNs	**2,974**	**7,238**

[17] HealthPathways are free, online platforms offering the primary health workforce empirical advice on the assessment and management of various health presentations, including referral guidance to commensurate services, where relevant.

Stakeholder perspectives

What worked well?

Survey respondents described the resources as **useful, practical and easy-to-use overall, particularly in the provision of victim-survivor support and clinical guidance**. One resource that was particularly valued was the clinician audit pathways safety spreadsheet, which provided structural assistance to some practices in identifying potential FDSV risks, assessing client and family safety, and recommending tailored supports specific to patient circumstances.

"We've been receiving some really good feedback about some of the resources that we've developed as well, like we've got these referral pathway flow charts that we've developed, which has a bit of a decision tree element to it as well, but also like some of those clinical indicators to look out for" (PHN staff member)

"And then another feedback that we received was around the Power and Control Wheel that the GP was like, this is a really fantastic resource. And, you know, I wasn't aware of this, and I'd absolutely like use this in my consultation" (PHN staff member)

Others highlighted the **clarity, practicality and informative nature of the suite of resources** they were provided with. A small number of staff praised the usefulness of having resources prior to and during the training sessions to reinforce their learning, and their desire to have more of these resources, particularly in consultation rooms, waiting rooms and bathrooms as prompts and reminders to think about FDSV.

What could be improved?

While most survey respondents highlighted the value of the FDSV resources distributed before, during and after training, some found them to be **lengthy and impractical.** For example, interviewees suggested that they would find 'cheat sheets', or quick guides and factsheets that promptly allow for clinicians to search for the signs of FDSV and recommended strategies as they arise useful. Resourcing for non-clinical staff may also involve providing additional information and training to help them contribute effectively to the delivery of appropriate support and care, when working in collaboration with the medical professionals and practitioners at their clinic. There was also more opportunity to integrate FDSV resources in existing tools, such as HealthPathways and user-friendly phone lists, and to better tailor resources for specific roles (as some found the resources they were given not directly relevant to their line of work). The language used in a small number of resources was called into question from a safety and appropriateness perspective, such as the DV Brochure entitled 'Charmed and Dangerous' and subtitled 'A woman's guide for reclaiming a healthy relationship'. Others indicated the need for more simple, visual-based resources, as well as an online repository in which all FDSV resources are made available for reference and easy access.

"Too long and too academic. Need something more practical and easy to look up information to help patients"

"Time is a real constraint for GPs so 'cheat' sheets are invaluable"

"Given that the training is delivered to non-clinical staff as well, including more information and training on how they can assist clinical staff in providing appropriate support and care would be beneficial"

Other capability building activities

Description of other capability building activities across PHNs

Most PHNs implemented a range of activities to enhance the primary care workforce's ability to recognise and respond to FDSV. Many PHNs established Communities of Practices (CoPs) to provide ongoing peer support and reflective learning. HNECCPHN facilitated CoPs for GPs and System Integrators, WVPHN convened CoPs aligned with its A-LIVES training, and NWMPHN hosted 2–3 CoP sessions annually. These forums enabled participants to share experiences, discuss complex cases, and explore quality improvement opportunities.

Co-location of specialist workers was another key strategy. NBMPHN embedded DFV, SV and CSA System Integrators from Relationships Australia in six primary care practices, while TASPHN placed support specialists from Engender Equality, SASS and Laurel House in participating clinics. BSPHN and ACTPHN also used System Integrators to provide case consultation, resource support, and practice visits.

Other capability building activities included networking events and quality improvement toolkits. HNECCPHN and NBMPHN organised education and networking dinners with sector partners, while NBMPHN distributed a DFV QI Toolkit to support practice-level change and BSPHN implemented flyer drops and feedback loops between training developers and clinics.

While these initiatives were generally well-received, PHNs noted that sustained engagement required ongoing relationship-building and responsiveness to practice needs. In some cases, limited capacity within practices or competing priorities posed as barriers to participation.

Number and type of capability building activities

Table 8 provides an overview of the capability building activities provided by each PHN, highlighting the diversity of approaches and numbers of attendees. NTPHN implemented the highest number of capacity building activities with a total of 204 attendees across the activities (average of 2.68 attendees per activity). In contrast, HNECCPHN recorded only two capacity building activities with a total of 68 attendees across both (average of 34 attendees per activity).

Table 8: Capability building activities implemented by each PHN and numbers of attendees (July 2022 to April 2025)

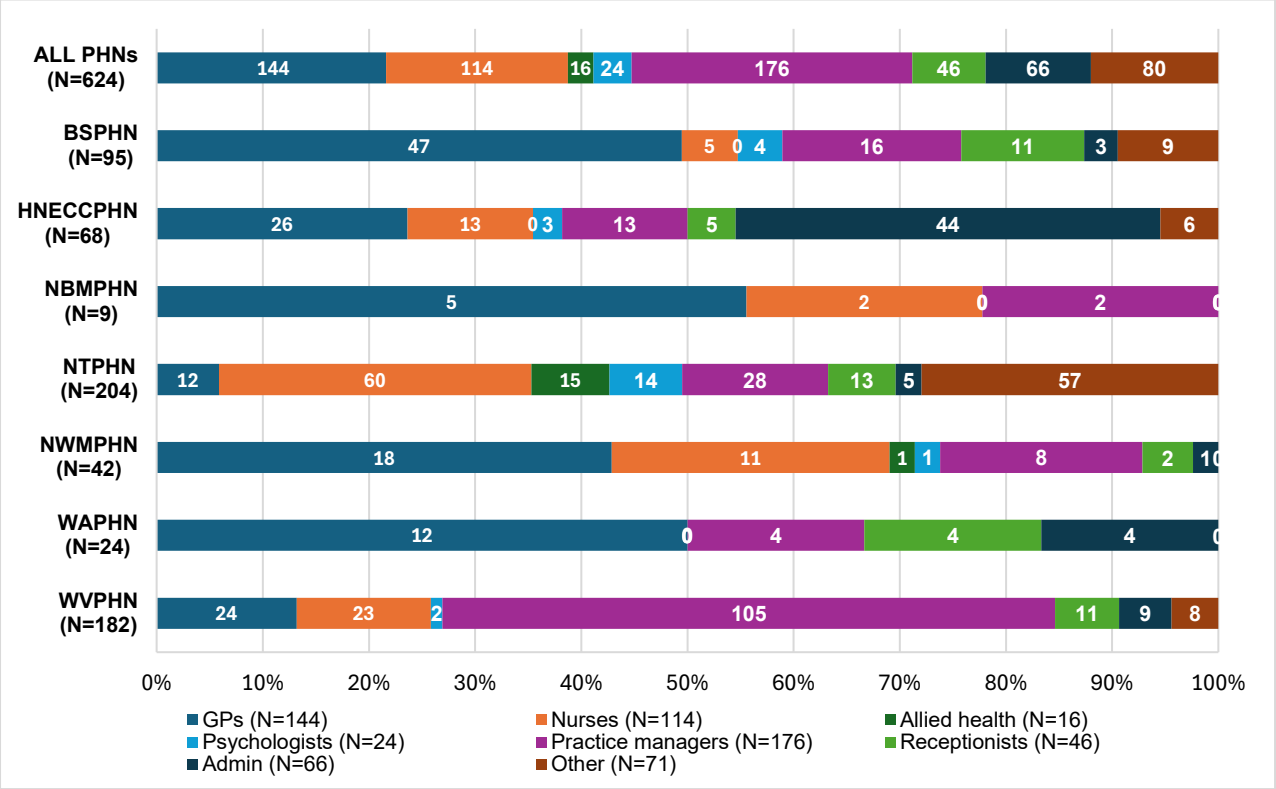
PHN	Capability building activity	Number of activities	Number of attendees*
BSPHN	FDSV GP Community of Practice	1	1
BSPHN	Practice Quality Improvement Consult	7	17
BSPHN	Program promotion and awareness	8	14
BSPHN	Referral outcome, case consults	1	1
BSPHN	Other	14	62
BSPHN	**Total**	**31**	**95**
HNECCPHN	DFV CPD and Networking Dinner	1	27
HNECCPHN	GP Dinner (PHN)	2	41
HNECCPHN	**Total**	**3**	**68**
NBMPHN	DFV QI Toolkit	2	8

PHN	Capability building activity	Number of activities	Number of attendees*
NBMPHN	How to use secure messaging	1	1
NBMPHN	**Total**	**3**	**9**
NTPHN	Medical & Forensic Management of Adult Sexual Assault	1	1
NTPHN	Partner Working Group Meeting	5	47
NTPHN	Primary Care Workforce Advisory Group	6	36
NTPHN	Project Briefing/Partner recruitment	10	18
NTPHN	SARC Sexual Assault Referral Services CPD Event	24	49
NTPHN	Stop DV Conference	2	2
NTPHN	Training & Resources Needs Assessment	2	9
NTPHN	Training Needs Analysis - Focus Group	3	20
NTPHN	Training Needs Analysis - Individual staff	23	22
NTPHN	**Total**	**76**	**204**
NWMPHN	Community of Practice education session	13	16
NWMPHN	Pathways to Safety program Wrap up meeting	12	25
NWMPHN	**Total**	**25**	**42**
WAPHA	GP Breakfast CPD	4	24
WAPHA	**Total**	**4**	**24**
WVPHN	FDSV Final Practice Consult	23	29
WVPHN	FDSV Initial Practice Consult	27	41
WVPHN	FDSV Practice Quality Improvement Consult	62	112
WVPHN	FDSV Final Practice Consult	23	182
WVPHN	**Total**	**112**	**182**
All PHNs	**-**	**255**	**624**

* Note: Some individuals may have attended more than one capability building activity

The capability building activities implemented by the PHNs had a total of 624 attendees, noting there may be some individuals who attended more than one activity. Some activities were aimed at GPs, nurses, psychologists and allied health professionals, while others were delivered to practice managers, receptionists and administrative staff. Overall, 28% of the attendees were practice managers (n=176 of 624), 23% were GPs (n=144 of 624), 18% were nurses (n=114 of 624), 10.6% were administrative staff (n=66 of 624), 7.4% were receptionists (n=46 of 624), 3.8% were psychologists (n=24 of 624), and 2.6% were allied health professionals (n=16 of 624). Figure 2 provides an overview of the nature and number of staff engaging in these other capability building activities, stratified by PHN.

Figure 2: Other capability building activity engagement by staff type and PHN (July 2022 to April 2025)



Stakeholder perspectives

What worked well?

Interviewees valued ongoing peer supports that sit alongside training—especially the CoPs and peer forums that give clinicians a safe place to test ideas and learn from each other—which were deemed a practical extension of training that "made [clinicians] feel supported and empowered throughout the process".

"I've gotten a lot out of the CoP… [I go] to learn from them and I can pass it on to my colleagues here." (GP)

A consistent theme was inter-agency collaboration, networking, knowledge sharing and cross-PHN peer-learning, which was perceived as an "accelerator" for improved practice that created a culture of "learning rather than competition". These forums also helped normalise conversations about FDSV and helped PHN staff to translate what they were learning into practice improvements.

"The amazing support and enthusiasm of the national collective of PHNs, which has been a huge enabler. It's quite unusual in the PHN context to have that kind of strong network of peer support in a learning environment rather than a kind of competitive environment." (PHN staff member)

"So, you know, going to different forums and conferences and workshops… we are constantly… engaging as part of our learning, as well as tailoring it to the training that we are designing and delivering." (System Integrator)

"I think that the PHN collective has been super helpful... because [I can check in] if I'm pushing too far out of scope in customising it in this way or just sort of testing those boundaries of what we're doing …that's been fantastic." (PHN staff member)

Similarly, survey respondents expressed appreciation for the CoPs and peer-learning opportunities. These were valued both in terms of the insights and practical strategies that were shared, but also how these opportunities contributed to their ability to collectively enhance the quality of care provided to victim-survivors at practices within their regions.

Co-location models, where System Integrators were embedded in practices, were considered to be especially helpful for timely, case-specific advice and warm consults. One PHN reported co-location at an AMS, allowing on-the-spot support that met GPs "where they're at". In NBMPHN, co-location with an AMS was also perceived to have led to an increase in First Nations clients seeking advice and referrals for FDSV support.

What could be improved?

Several interviewees described the 'churn' in GP workforce as undermining continuity of CoPs/peer forums and other practice supports, meaning teams had to repeatedly start from scratch when new clinicians or staff came on board. Other PHNs from rural and remote communities expressed a desire for greater supports tailored to nurses, who are primarily responsible for interacting with FDSV patients on a regular basis in these locales.

"Also, the turnover of GPs is huge as well. So the knowledge leaves once those GPs go. That knowledge leaves as well" (System Integrator)

System integration activities

Description of system integration activities

System integration was a key focus of implementation. PHNs engaged in a wide range of activities that strengthened collaboration between primary care and the broader FDSV service system, that fostered and improved referral pathways to specialist FDSV services, and that enhanced feedback loops to primary care'.

Many PHNs established formal partnerships with state and territory governments, local health districts, and specialist services. ACTPHN worked closely with the ACT Government's DFSV Office, co-hosted a table at the GP Policy Forum, and participated in the SPC Pilot Steering Committee and Roundtable. SAPHN Consortium convened a GP Advisory Panel and a Lived Experience Advisory Panel (LEAP) to inform program design and contributed to the Royal Commission into Family, Domestic and Sexual Violence.

Several PHNs participated in whole-of-Pilot initiatives, such as WVPHN's Sustainable Integration Needs Assessment Project, which explored systems challenges and opportunities for long-term integration. HNECCPHN conducted integration workshops in Tamworth and the Central Coast to connect specialist FDSV services with acute care settings, and NTPHN held joint planning meetings with NT Health and participated in the Against Sexual Violence Network NT.

Integration efforts also included co-design workshops, interagency meetings, and collaborative training events. TASPHN conducted lived experience consultations and market research to

understand community attitudes and service responses across rural, regional and metropolitan areas. WAPHA facilitated co-design workshops with practice staff and System Integrators and planned CPD events focused on medico-legal considerations and clinical documentation.

While integration was widely recognised as essential for sustainable change, PHNs reported that it required time, trust, and consistent leadership. Challenges included navigating different service systems, managing confidentiality and information-sharing protocols, and ensuring that integration efforts were adequately resourced and embedded within broader health system reforms.

Meaningful interactions between System Integrators and primary care

As shown in Table 9, CRM and Tracker data recorded a total of 8,446 meaningful interactions between System Integrators and primary care staff across 1,124 practices between July 2022 and April 2025. Meaningful interactions relate to the ways in which System Integrators engaged with practices that were likely to have an impact on their ability to recognise and respond to FDSV. The number of recorded meaningful interactions varied across the PHNs but, in general, correlated with the length of time that PHNs have participated in the Pilot, ranging from 23 recorded by WAPHA to 3,335 recorded by BSPHN. No meaningful interactions had been recorded as yet for SAPHA and TASPHN given implementation timeframes.

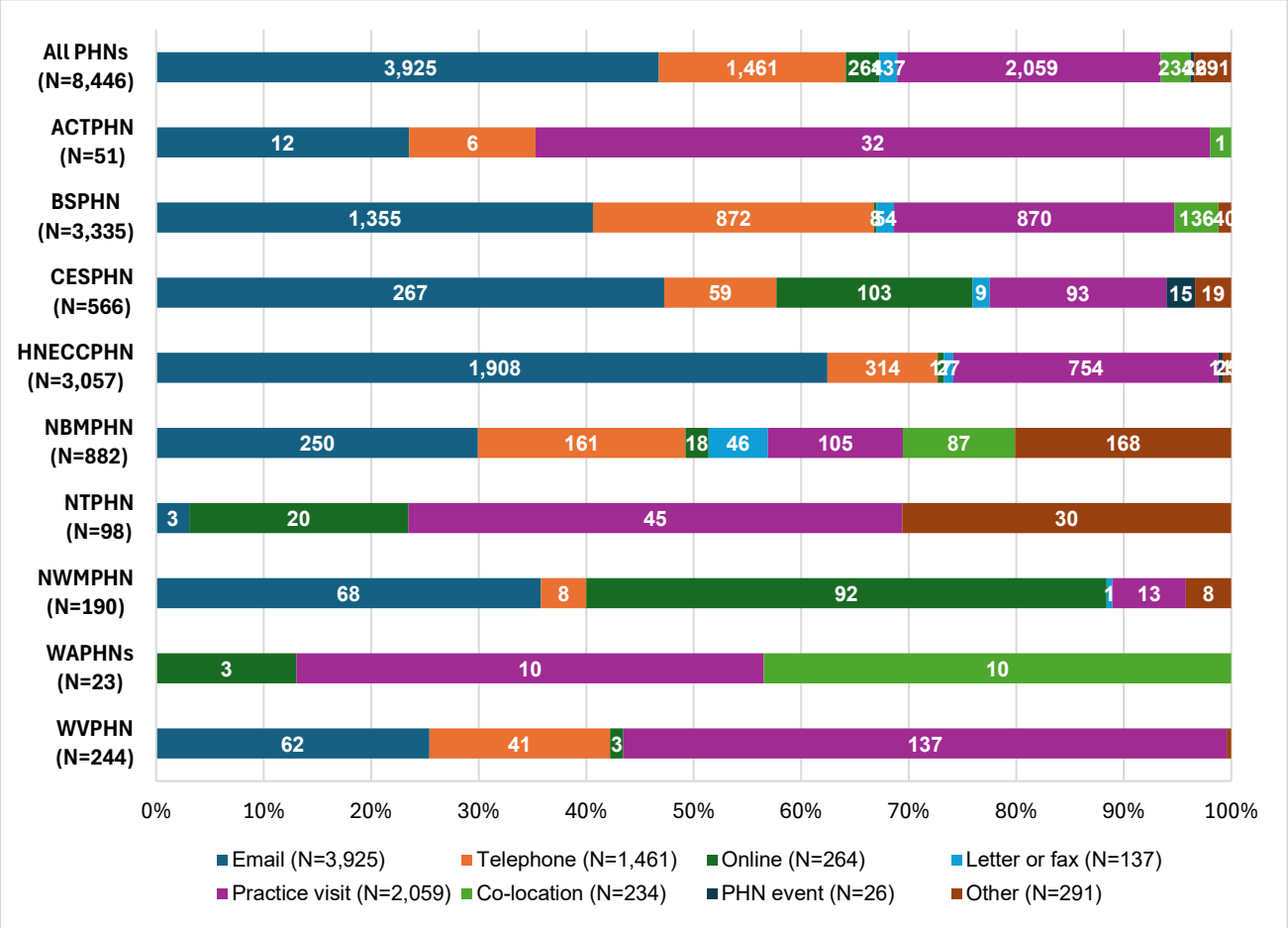
Table 9: Number of meaningful interactions between System Integrators and primary care workers (July 2022 to April 2025)

PHN	Total number of interactions	Number of practices engaged*	Average number of interactions per practice
ACTPHN	51	15	3.4
BSPHN	3,335	287	11.6
CESPHN	566	202	2.8
HNECCPHN	3,057	385	7.9
NBMPHN	882	100	8.8
NTPHN	98	43	2.3
NWMPHN	190	42	4.5
SAPHN Consortium	0	0	0.0
TASPHN	0	0	0.0
WAPHA	23	5	4.6
WVPHN	244	47	5.2
All PHNs	**8,446**	**1,124**	**7.5**

* Practices engaged that had at least one meaningful interaction (excluding interactions purely administrative in nature)

As shown in Figure 3, almost half of the meaningful interactions occurred by email between System Integrators and primary care workers, with practice visits accounting for about a quarter of interactions.

Figure 3: Mode of meaningful interactions between System Integrators and primary care workers (July 2022 to April 2025)



As shown in Table 10, 53% of the meaningful interactions involved relationship building (n=4,457 of 8,446). Around two-fifths of these meaningful interactions were recorded by HNECCPHN (43%, n=1,938 of 4,457). Relationship building activities were multifaceted in nature, and included regular catchups, drop-in visits, follow-up visits and check-ins. Additionally, 2,974 meaningful interactions involved distributing resources (e.g., FDSV related info or flyers) and 575 involved other capability building activities, with most of these recorded by BSPHN (61%, n=351 of 575).

A total of 3,132 instances of providing general or specific FDSV advice were recorded by the participating PHNs, ranging from 23 recorded by ACTPHN to 1,494 by BSPHN. FDSV-related advice included case consultations, individual referral recommendations and post-referral feedback. As shown in Table 9, 1,513 direct referrals were recorded, over half of which came from BSPHN (57%, n=855 of 1,513), followed by HNECCPHN (27%, n=404 of 1,513) and NBMPHN (13%, n=204 of 1,513). A total of 808 instances of feedback to practices about direct referrals were also recorded, almost all of which came from BSPHN, HNECCPHN and NBMPHN (98%, n=793 of 808). Additionally, 61 FDSV service referrals to GPs were recorded, including 59 from BSPHN, and 1 each from HNECCPHN and NBMPHN, and 1,008 contacts relating to supports for referred clients were recorded, almost all of which were recorded by BSPHN, HNECCPHN and NBMPHN (98%, n=990 of 1,008).

Table 10: Nature of meaningful interactions between System Integrators and primary care workers (July 2022 to April 2025)

PHN	Total number of interactions	Nature of meaningful interactions*	-	-	-	-	-	-	-	-	-
-	-	Relationship building	Resource provision	Training	Capability building activities	FDSV advice (general or patient-specific)	Direct referrals	Feedback to Practice/ services about direct referrals	FDSV service referral to GP	Support for referred clients	Other
ACTPHN	**51**	29	38	5	0	23	1	1	0	4	0
BSPHN	**3,335**	1,581	1,246	161	351	1,494	855	461	59	543	4
CESPHN	**566**	223	205	144	0	233	44	12	0	7	2
HNECC	**3,057**	1,938	1138	127	3	735	404	162	1	285	23
NBMPHN	**882**	500	220	113	3	567	204	170	1	162	0
NTPHN	**98**	10	11	30	75	15	3	0	0	0	0
NWMPHN	**190**	63	68	66	26	40	0	0	0	0	0
SAPHN Consortium	**0**	0	0	0	0	0	0	0	0	0	0
TASPHN	**0**	0	0	0	0	0	0	0	0	0	0
WAPHA	**23**	15	5	8	4	0	0	0	0	0	0
WVPHN	**244**	98	43	67	112	25	2	2	0	7	12
All PHNs	**8,446**	**4,457**	**2,974**	**721**	**575**	**3,132**	**1,513**	**808**	**61**	**1,008**	**41**

* Total sum of the different types of interactions is higher than the total number of meaningful interactions as each interaction could involve multiple activities.

Advice and support provided by **System Integrators** to primary care workers

As shown in Table 11, a total of 3,132 occasions of primary care workers seeking advice and support from System Integrators have been recorded across the 11 participating sites between July 2022 and April 2025. Of these, 2,986 related to DFV, 211 related to SV and 144 related to CSA. System Integrators provided advice on general referral pathways advice during 1,429 interactions, patient-specific support during 1,750 interactions, and general FDSV advice or informal training during 1,124 interactions.

Table 11: Nature of advice provided by System Integrators to primary care workers (July 2022 to April 2025)

PHN	Total number of interactions	FDSV topic area: DFV	FDSV topic area: SV	FDSV topic area: CSA	FDSV topic area: PUVA	FDSV topic area: Other	Advice focus: General advice or informal training	Advice focus: Referral pathway options	Advice focus: Individual patient-specific	Advice focus: About multiple patients with similar issues	Advice focus: Other
ACTPHN	**23**	7	18	17	1	1	21	24	3	1	0
BSPHN	**1,494**	1,454	124	80	129	7	640	715	1121	38	0
CESPHN	**233**	232	1	0	0	0	31	38	76	1	2
HNECC	**735**	670	18	11	3	0	288	476	195	8	3
NBMPHN	**567**	545	31	28	4	0	88	126	324	47	0
NTPHN	**15**	15	9	2	1	0	15	12	1	0	0
NWMPHN	**40**	40	4	5	1	0	35	32	11	0	0
SAPHN Consortium	**0**	0	0	0	0	0	0	0	0	0	0
TASPHN	**0**	0	0	0	0	0	0	0	0	0	0
WAPHA	**0**	0	0	0	0	0	0	0	0	0	0
WVPHN	**25**	23	6	1	0	4	6	6	19	0	3
All PHNs	**3132**	**2986**	**211**	**144**	**139**	**12**	**1124**	**1429**	**1750**	**95**	**8**

Note: System Integrators may cover multiple topic areas and provide multiple types of advice in one interaction and hence the numbers do not add up to the totals

As shown in Table 12, System Integrators recorded a total of 660 referrals being made or recommended during their interactions with primary care workers to provide advice and support between July 2022 and April 2025. Around 56% of the referrals made or recommended were to specialist DFV services (n=372 of 660), with 5% referrals made or recommended to specialist SV services (n=31 of 660) and 7.5% to mental health services (n=50 of 660).

Table 12: Nature of referrals made or recommended during System Integrator advice to primary care workers (July 2022 to April 2025)

PHN	Total number of interactions	Referrals made or recommended during interactions between System Integrators and primary care workers	-	-	-	-	-	-	-	-	-
-	-	DFV	SV	CSA	Child Protection	Housing	Legal	Mental health	Financial	Police	Other
ACTPHN	**23**	1	0	0	0	0	0	0	0	0	0
BSPHN	**1,494**	56	14	11	4	15	21	29	7	3	59
CESPHN	**233**	30	1	0	0	0	1	1	0	0	0
HNECCPHN	**735**	114	10	3	2	14	8	13	7	3	10
NBMPHN	**567**	151	2	0	4	3	5	7	1	0	8
NTPHN	**15**	3	0	0	0	0	0	0	0	0	0
NWMPHN	**40**	3	0	0	0	1	0	0	0	0	0
SAPHN Consortium	**0**	0	0	0	0	0	0	0	0	0	0
TASPHN	**0**	0	0	0	0	0	0	0	0	0	0
WAPHA	**0**	0	0	0	0	0	0	0	0	0	0
WVPHN	**25**	14	4	0	0	5	3	0	3	1	5
All PHNs	**3,132**	**372**	**31**	**14**	**10**	**38**	**38**	**50**	**18**	**7**	**82**

Note: Some occasions included multiple referrals made or recommended to different services

Stakeholder perspectives

Interviewees consistently described System Integrators as approachable, responsive and trusted first points of contact who help GPs navigate referral options and keep their work moving in moments of uncertainty.

"And just the relief that I see on all of the practice staff when we go 'this is big and scary and you've had this conversation now, what do you do now?' Here's your friend to call. You can call them. Just like that relief." (System Integrator)

What worked well?

The significance played by System Integrators in embedding primary care and specialist service systems was a clear theme among interviewees, both in terms of the specific supports they provided to GPs, such as post-training support, secondary consults and clear advice about referral pathways, and also in terms of their role in the Pilot more broadly.

"There's a whole system set up now that everyone knows who to refer to, you know, the linkers where they are, what to do and everything." (PHN staff member)

System Integrators were perceived as collaborative, professional and an accessible first point-of-contact that can be trusted in times of crisis.

"I think it's [local linker] that does quite a bit of that where essentially she's advising clinicians. I cannot emphasise how important that role is. Like the training is one thing, but to have somebody that we can continue to follow up, I know a lot of my team has used her... Local linker is generous with her time, and she's so knowledgeable in that space." (GP)

GP interviewees reported that System Integrators were a "huge asset" to the Pilot because they could readily provide support either in person or over the phone, especially around referrals and helping GPs locate appropriate services for their patients.

"I think the advantage is that because we have a link worker here, it is so much easier…. If I don't have a linker worker I'm floundering… having a link worker attached to this organisation is the most beautiful thing." (GP)

Administrative staff also valued System Integrator support, particularly their reliability, availability and responsiveness.

"Both of the linkers that we have worked with have been utterly incredible, via email and phone call. We've been able to correspond with them as needed that way." (Admin staff)

"If we don't get a call straight away, there's always an e-mail they think, hey, I've got your call. I'm following it up. It is in the works, so there's always really great communication between the linker and the practice." (Admin staff)

System Integrators were also highly valued for their knowledge of the FDSV system, and for their willingness to 'show up' at inter-agency settings and share their knowledge of specialist services and referral pathways.

"It could be, you know, that holistic sort of support... men's behaviour change programmes etc... whatever the referred person is needing at the time. By attending these meetings, we get to hear on the ground what's happening." (PHN staff member)

What could be improved?

A small number of PHNs noted that System Integrators could play a more prominent role in bridging the gap between the primary care sector workforce and referral services in a way that is proactive, rather than crisis driven. Such an approach would ensure that GPs and System Integrators are consistent in their messaging and responses when working with FDSV victim-survivors.

"That would also include that very important feedback loop to the primary care provider about the type of response that has been received by the client… Just to build some of those bridges between that primary care provider network and domestic violence and sexual violence responses that are funded throughout the community." (System Integrator)

System Integrators also expressed they felt they were insufficiently remunerated for their role, including time taken for travel, referral follow-ups, and even working out-of-hours (e.g., handing out FDSV flyers to women on trains after hours, and working with other transient and vulnerable

populations). While many saw this as a negative, others commented that “you just have to get on with the job and do the best job possible to support women who need the support”.

There was a common barrier that PHN interviewees raised related to insufficient (or inefficient) integration of practice software, which not only created additional work for GPs, but also hampered the real goal of system integration between practices and specialist FDSV services. Furthermore, there was shared concern that the lack of software integration could have legal and other safety implications particularly in instances where women disclose FDSV to GPs that involves children because of mandatory reporting requirements.

“So, I send my referrals, and they’re not integrated into a software unfortunately. So that’s the other thing I could ask for improvement. If the referrals are integrated into a software, it should upload automatically so everybody can see this patient has a DV issue and it should be easy to integrate… It takes at least 10-15 minutes extra for me to actually work on them, which we don’t have time for, but because I’m working actively and I feel if services are available, they should be used and that’s why I take the extra time to do all this.” (GP)

Other barriers to effective implementation of system integration activities were noted, including short-term funding, the lasting impact of COVID-19, and persistent challenges with staff retention and turnover (both of primary care staff and System Integrators). Short-term funding of the Pilot, particularly in newly established PHNs, was a particular concern because of the impact it had on their ability to plan for implementation in the longer-term and to establish longstanding partnerships and networks.

“So it’s really important when Piloting anything to make sure there is that ability to keep the recurrent funding going so that people can use it.” (GP)

For established PHNs, COVID-19 was thought to have ‘undone’ much of the relationship building established between PHNs and FDSV participating services. Whilst staff retention and turnover was widely reported to have impacted knowledge transfer for both new and established PHNs, and to have hindered their ability to effectively implement their system integration activities.

“And then within about a year, they need the training again because they've lost staff or something else has happened and they need it all over again. The retention like it's not there. So and it's really hard for the practice to be responsible for the sustainability of the knowledge when they don't have salaried staff in terms of GPs" (PHN staff member)

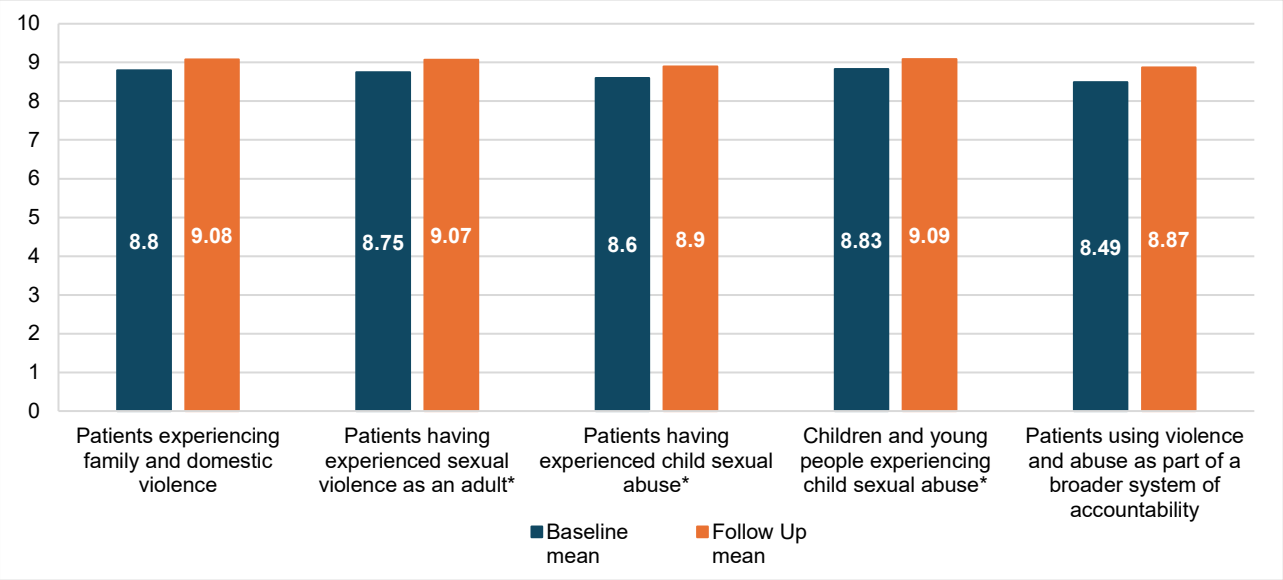
Early outcomes of the SPC Pilot

The SPC Pilot appears to have been instrumental in enhancing the ability of the primary care workforce to recognise and respond to FDSV.

Awareness

As shown in Figure 4, survey respondents reported relatively high levels of **agreement that the primary care workforce has a role to play in identifying and supporting patients experiencing FDSV and CSA** at baseline (ranging from 8.6 to 8.83 on a 10-point rating scale). Survey respondents reported slight improvements on this measure as a result of their engagement with the SPC Pilot, with a statistically significant increase of 0.28 (from 8.8 to 9.08) at follow-up.

Figure 4: Agreement that the primary care workforce has a role to play in recognising and supporting patients experiencing FDSV and CSA and patients using violence and abuse



* Change presented in the figure was not statistically significant (i.e., P value > 0.05 using two-sample t-tests assuming unequal variance)

Table 13 shows that clinicians who completed the follow-up survey reported an increase in their agreement that the primary care workforce has a role to play in identifying and supporting patients experiencing FDSV, with a statistically significant increase of 0.37 (from 8.79 to 9.16) in their average rating on a 10-point scale. There were no statistically significant increases in the average ratings reported by practice managers or administrative staff before and after their engagement with the SPC Pilot activities.

Table 13: Agreement that the primary care workforce has a role to play in recognising and supporting patients experiencing FDSV and CSA and patients using violence and abuse (by role)

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
Clinicians	**Baseline – N**	541	321	321	320	535
-	**Baseline – Mean (SD)**	8.79 (1.72)	8.68 (1.81)	8.48 (1.94)	8.75 (1.83)	8.49 (1.97)

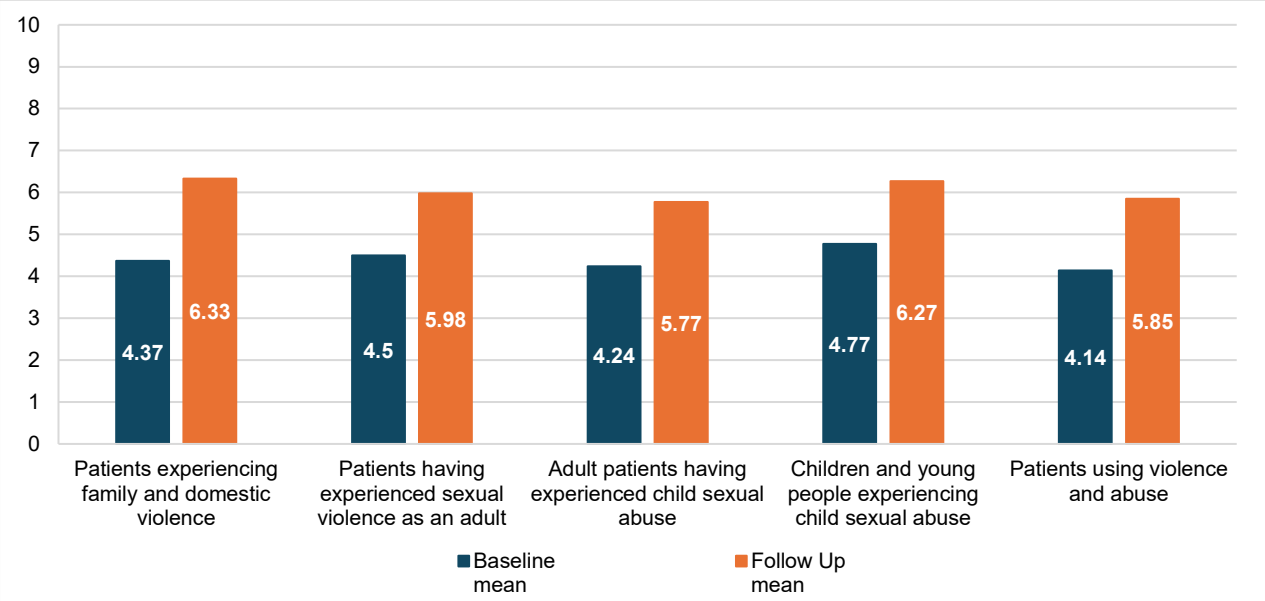
Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
-	**Follow-up – N**	88	56	56	56	88
-	**Follow-up – Mean (SD)**	9.16 (1.49)	9.07* (1.64)	8.73* (2.03)	8.98* (1.63)	8.83* (1.66)
Practice managers	**Baseline – N**	95	53	53	52	95
-	**Baseline – Mean (SD)**	8.64 (1.85)	9.15 (1.61)	9.02 (1.67)	9.10 (1.94)	8.85 (1.94)
-	**Follow-up – N**	26	11	11	11	26
-	**Follow-up – Mean (SD)**	8.88* (1.31)	9.09* (1.38)	9.18* (1.33)	9.64* (0.67)	8.65* (1.32)
Administrative staff	**Baseline – N**	189	84	83	83	189
-	**Baseline – Mean (SD)**	8.92 (1.58)	8.90 (1.89)	8.80 (2.00)	8.96 (1.84)	9.04 (2.06)
-	**Follow-up – N**	33	14	14	15	33
-	**Follow-up – Mean (SD)**	9.03* (1.29)	9.07* (1.27)	9.36* (0.93)	9.07* (1.49)	8.49 (1.20)
All respondents	**Baseline – N**	825	458	457	455	819
-	**Baseline – Mean (SD)**	8.80 (1.70)	8.75 (1.81)	8.60 (1.93)	8.83 (1.84)	8.49 (1.99)

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
-	**Follow-up – N**	147	81	81	82	147
-	**Follow-up – Mean (SD)**	9.08 (1.41)	9.07* (1.53)	8.90* (1.81)	9.09* (1.52)	8.87 (1.41)

* Note: Change in the ratings between baseline and follow-up were not statistically significant (i.e., P value > 0.05 using two-sample t-tests assuming unequal variance)

In contrast to the above, at baseline, survey respondents generally had relatively low levels of **familiarity with the relevant guidelines, legislation and policies about the primary care sector's responsibilities to recognise and support patients experiencing FDSV and CSA**, as shown in Figure 5. However, their levels of familiarity with the relevant FDSV and CSA guidelines, legislation and policies appeared to increase as a result of their engagement with the SPC Pilot. In particular, familiarity with the FDSV-related items revealed a statistically significant increase of 1.96 (from 4.37 to 6.33 on a 10-point scale) in the average rating between baseline and follow-up. There was a similar increase of 1.71 (from 4.14 to 5.85) in survey respondents' familiarity with the relevant guidelines, legislation and policies about the primary care sector's responsibilities to identify and support patients using violence and abuse.

Figure 5: Familiarity with the relevant guidelines, legislation and policies about recognising and supporting patients experiencing FDSV and CSA, and patients using violence and abuse



As shown in Table 14, at follow-up, clinicians and practice managers demonstrated statistically significant increases in their levels of familiarity with the relevant guidelines, legislation and policies about recognising and supporting patients experiencing FDSV and CSA, and patients using violence and abuse. Clinicians showed relatively large increases in their average levels of familiarity with guidelines, legislation and policies about recognising and supporting patients experiencing FDSV (increase of 2.1; from 4.55 to 6.65) and children and young people experiencing child sexual abuse (increase of 1.9; from 4.74 to 6.64). Despite having slightly lower baseline levels of familiarity, practice managers showed larger increases in their average levels of familiarity with guidelines, legislation and policies about recognising and supporting patients experiencing FDSV (increase of 2.48; from 4.10 to 6.58) and adult patients who had experienced child sexual abuse (increase of 2.48; from 4.16 to 6.64).

Table 14: Familiarity with relevant guidelines, legislation and policies about recognising and supporting patients experiencing FDSV and CSA, and patients using violence and abuse (by role)

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
Clinicians	**Baseline – N**	539	320	320	319	537
-	**Baseline – Mean (SD)**	4.55 (2.26)	4.47 (2.35)	4.15 (2.45)	4.74 (2.70)	4.14 (2.44)
-	**Follow-up – N**	88	56	56	56	88
-	**Follow-up – Mean (SD)**	6.65 (2.02)	6.29 (2.48)	5.93 (2.56)	6.64 (2.50)	6.03 (2.49)
Practice managers	**Baseline – N**	94	51	51	50	93
-	**Baseline – Mean (SD)**	4.10 (2.77)	4.59 (3.02)	4.16 (2.99)	4.70 (3.15)	4.11 (2.60)
-	**Follow-up – N**	26	11	11	11	26
-	**Follow-up – Mean (SD)**	6.58 (1.33)	6.45 (1.86)	6.64 (1.80)	6.91 (1.70)	5.73 (1.78)

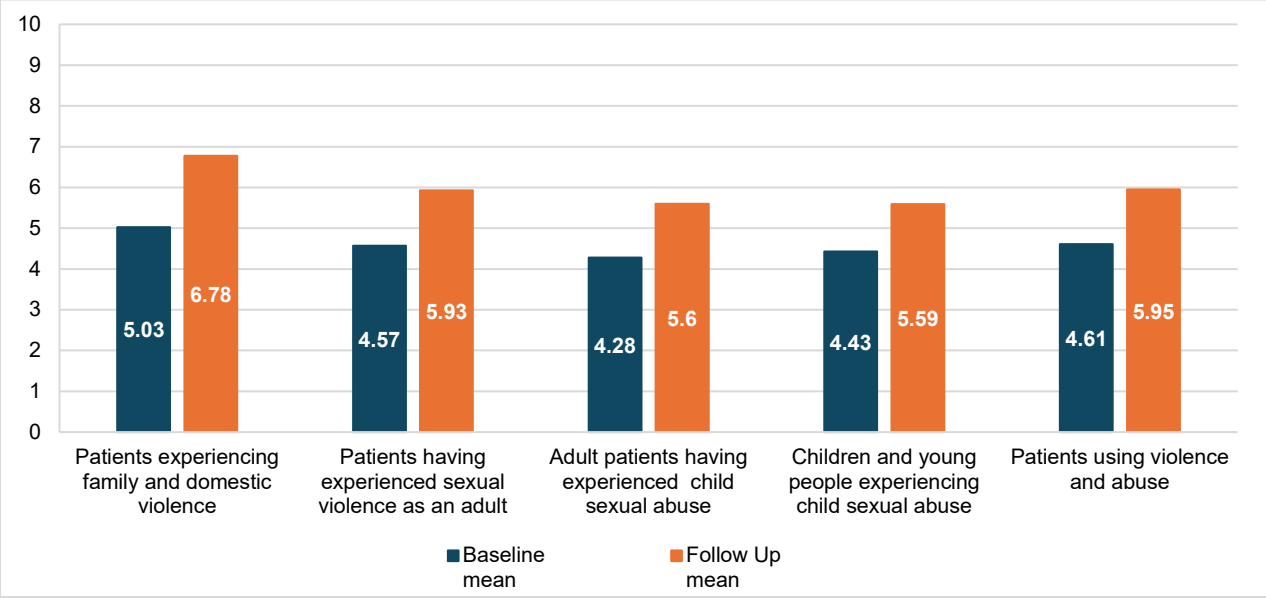
Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
Administrative staff	**Baseline – N**	187	83	82	80	187
-	**Baseline – Mean (SD)**	3.98 (3.12)	4.54 (3.84)	4.67 (3.82)	4.93 (3.74)	4.13 (2.82)
-	**Follow-up – N**	33	14	14	14	33
-	**Follow-up – Mean (SD)**	5.27 (2.80)	4.36* (3.50)	4.43* (3.37)	4.29* (3.24)	5.45* (2.66)
All respondents	**Baseline – N**	820	454	453	449	817
-	**Baseline – Mean (SD)**	4.37 (2.55)	4.50 (2.75)	4.24 (2.81)	4.77 (2.95)	4.24 (2.55)
-	**Follow-up – N**	147	81	81	81	147
-	**Follow-up – Mean (SD)**	6.44 (2.19)	5.98 (2.68)	5.77 (2.68)	6.27 (2.68)	5.85 (2.42)

* Note: Change in the ratings between baseline and follow-up were not statistically significant (i.e., P value > 0.05 using two-sample t-tests assuming unequal variance)

Recognising

As shown in Figure 6, at baseline, survey respondents also had relatively low levels of **confidence in their ability to recognise patients experiencing FDSV and CSA and patients using violence and abuse**. However, there were statistically significant increases in their confidence levels as a result of their engagement with the SPC Pilot, particularly confidence in their ability to recognise patients experiencing FDSV which had a statistically significant increase of 1.75 (from 5.03 to 6.78 on a 10-point scale) in the average rating between baseline and follow-up.

Figure 6: Confidence in recognising patients experiencing FDSV and CSA and patients using violence and abuse



Note: All of the changes in the ratings between baseline and follow-up presented in this figure were statistically significant (i.e., P value < 0.05 using two-sample t-tests assuming unequal variance)

Clinicians, practice managers and administrative staff all demonstrated statistically significant increases in their levels of confidence in their ability to recognise patients experiencing FDSV, with practice managers showing the largest increase in their average rating (increase of 2.03; from 4.59 to 6.62). As shown in Table 15, clinicians also showed statistically significant increases in their levels of confidence to recognise patients experiencing sexual violence and child sexual abuse, as well as patients using violence and abuse.

Table 15: Confidence in recognising patients experiencing FDSV and CSA and patients using violence and abuse

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
Clinicians	**Baseline – N**	527	311	311	310	471
	Baseline – Mean (SD)	5.20 (2.00)	4.62 (2.30)	4.38 (2.41)	4.47 (2.06)	4.32 (2.33)
	Follow-up – N	87	56	55	56	87

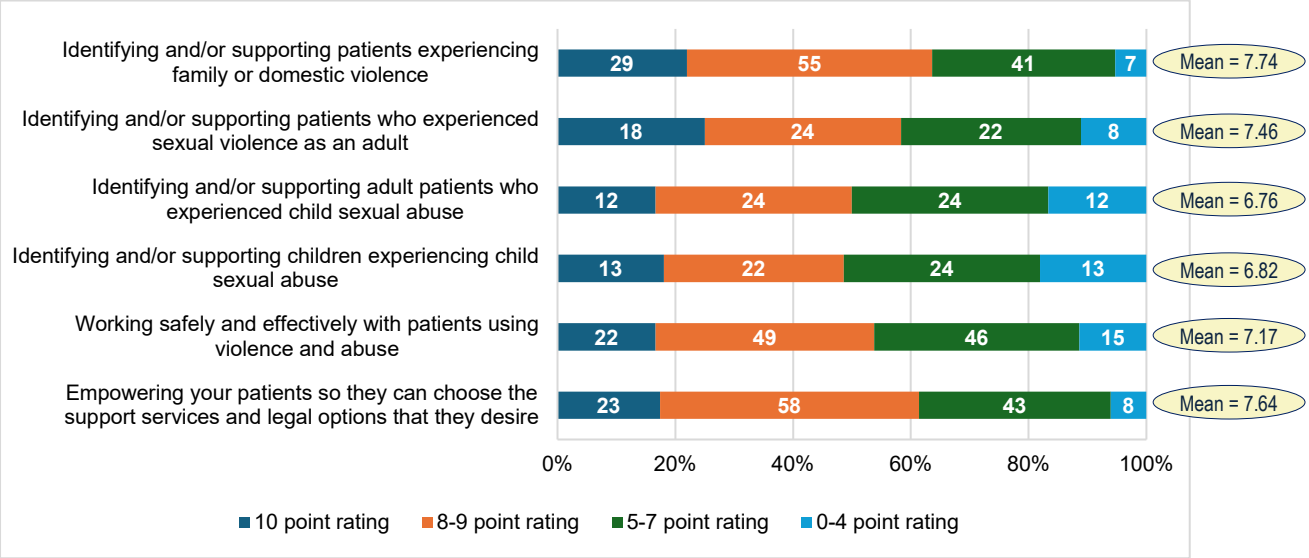
Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
	Follow-up – Mean (SD)	7.14 (1.82)	6.46 (2.35)	6.11 (2.22)	6.02 (2.12)	6.09 (2.23)
Practice managers	**Baseline – N**	76	49	49	49	74
	Baseline – Mean (SD)	4.59 (2.39)	4.88 (2.61)	4.16 (2.82)	4.68 (2.29)	4.75 (2.75)
	Follow-up – N	26	11	11	11	26
	Follow-up – Mean (SD)	6.62 (1.42)	5.45* (1.97)	5.18* (2.14)	5.65* (2.23)	5.18* (2.23)
Administrative staff	**Baseline – N**	164	81	81	79	164
	Baseline – Mean (SD)	4.68 (2.38)	4.18 (2.74)	3.95 (2.83)	5.01 (3.74)	4.77 (3.37)
	Follow-up – N	33	14	14	14	33
	Follow-up – Mean (SD)	5.97 (2.42)	4.14* (3.06)	3.93* (2.97)	5.97* (3.24)	3.93* (3.34)
All respondents	**Baseline – N**	767	441	441	438	709
	Baseline – Mean (SD)	5.03 (2.14)	4.57 (2.42)	4.28 (2.54)	4.61 (2.46)	4.43 (2.59)
	Follow-up – N	146	81	80	81	146

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
	Follow-up – Mean (SD)	6.78 (1.96)	5.93 (2.57)	5.60 (2.47)	6.27 (2.68)	5.59 (2.56)

* Note: Change in the ratings between baseline and follow-up were not statistically significant (i.e., P value > 0.05 using two-sample t-tests assuming unequal variance)

Figure 7 shows the follow-up survey respondents perceived their engagement with the SPC Pilot—including their participation in training and capability building activities and access to resources and other support provided by the System Integrators—had substantially enhanced their **ability to recognise and respond appropriately to patients experiencing FDSV and CSA as well as patients using violence and abuse**. Over a third of all ratings were at the top of the 10-point scale ranging from 0 being "Not at all useful" to 10 being "Very much so", with an overall mean rating of 7.34 points across all the potential impacts. Survey respondents perceived the biggest improvements were in their ability to recognise and support patients experiencing family and domestic violence, and ability to empower their patients so they can choose the support services that they want to access.

Figure 7: Follow-up survey perceptions of the impact of the overall SPC pilot on their ability to recognise and respond to patients experiencing FDSV and CSA and patients using violence and abuse

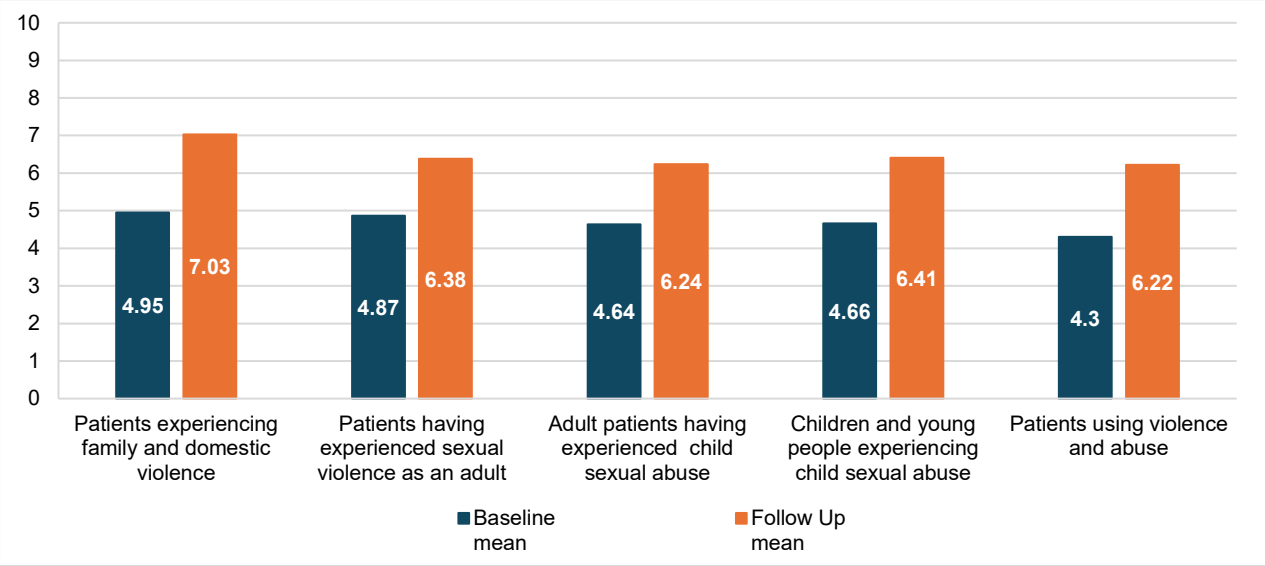


Responding

As shown in Figure 8, survey respondents reported relatively low levels of **confidence in their ability to respond appropriately to patients experiencing FDSV and CSA as well as patients using violence and abuse,** with their average ratings ranging from 4.3 to 4.95 at baseline. Overall, there

were relatively large increases in their levels of confidence which were statistically significant as a result of their engagement with the SPC Pilot, with the largest increases in their confidence in identifying patients experiencing FDSV (increase of 2.08; from 4.95 to 7.03) and patients using violence and abuse (increase of 1.92; from 4.3 to 6.22).

Figure 8: Confidence in appropriately responding to FDSV patients and patients using violence among the primary care sector



Note: All of the changes in the ratings between baseline and follow-up presented in this figure were statistically significant (i.e., P value < 0.05 using two-sample t-tests assuming unequal variance)

Clinicians, practice managers and administrative staff all demonstrated statistically significant increases in their levels of confidence in their ability to identify patients experiencing family and domestic violence and patients using violence and abuse. As shown in Table 16, clinicians demonstrated the largest statistically significant increases in the levels of confidence in their ability to respond appropriately to patients experiencing family and domestic violence (increase of 2.29 from 5.10 to 7.39), children and young people experiencing child sexual abuse (increase of 2.18 from 4.62 to 6.80), and patients using violence and abuse (increase of 2.15 from 4.27 to 6.42).

Table 16. Confidence in appropriately responding to FDSV patients and patients using violence among the primary care sector (by role)

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
Clinicians	**Baseline – N**	528	308	309	307	526

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
	Baseline – Mean (SD)	5.10 (2.24)	4.83 (2.30)	4.60 (2.38)	4.62 (2.57)	4.27 (2.43)
	Follow-up – N	88	56	55	56	88
	Follow-up – Mean (SD)	7.39 (1.63)	6.69 (2.20)	6.62 (2.00)	6.80 (2.06)	6.42 (2.17)
Practice managers	**Baseline – N**	91	49	49	50	91
	Baseline – Mean (SD)	4.84 (2.23)	5.06 (2.49)	4.65 (2.60)	4.72 (2.76)	4.32 (2.36)
	Follow-up – N	26	11	11	11	26
	Follow-up – Mean (SD)	6.81 (1.77)	6.00* (2.28)	6.18 (1.94)	6.36* (2.13)	5.85 (2.41)
Administrative staff	**Baseline – N**	185	81	80	80	186
	Baseline – Mean (SD)	4.60 (2.70)	4.91 (3.19)	4.79 (3.36)	4.76 (3.32)	4.37 (2.49)
	Follow-up – N	33	14	14	14	33
	Follow-up – Mean (SD)	6.24 (2.39)	5.43* (2.68)	4.79* (2.86)	4.86* (2.68)	6.00 (2.56)
All respondents	**Baseline – N**	804	438	438	437	803

Role	Timepoint	Patients experiencing family and domestic violence	Patients having experienced sexual violence as an adult	Adult patients having experienced child sexual abuse	Children and young people experiencing child sexual abuse	Patients using violence and abuse
	Baseline – Mean (SD)	4.95 (2.36)	4.87 (2.51)	4.64 (2.60)	4.66 (2.74)	4.30 (2.43)
	Follow-up – N	147	81	80	81	147
	Follow-up – Mean (SD)	7.03 (1.89)	6.38 (2.32)	6.24 (2.24)	6.41 (2.36)	6.22 (2.30)

* Note: Change in the ratings between baseline and follow-up were not statistically significant (i.e., P value > 0.05 using two-sample t-tests assuming unequal variance)

Referring

System Integrators received referrals directly from primary care staff for individuals needing support. As shown in Table 17, a total of 1,513 direct client referrals were recorded between July 2022 and April 2025. Such referrals can made directly to the System Integrators separately to a meaningful interaction with the practice and without any advice being provided by the System Integrators. Of the 1,513 direct client referrals recorded, 1,444 involved DFV victim-survivors (95%), 49 involved SV victim-survivors (3%), 30 involved CSA victim-survivors (mostly historical) (2%) and 18 involved PUVA (1%). Around 89% of the clients referred directly to the System Integrators were new referrals (i.e., accessing a specialist service for the first time) (n=958 of 1,074).

In Victoria, the FDV service system operates within the Multi-Agency Risk Assessment and Management (MARAM) Framework which sets out the responsibilities of different workforces in identifying, assessing and managing family violence risk across the service system. For the specialist services commissioned within this context (WVPHN and NWMPHN), their role was to provide education and guidance on the MARAM Framework and Information Sharing Schemes, and to refer victim-survivors to their local The Orange Door, a designated FDV support service. They did not directly receive referrals from primary care. In the WVPHN pilot site, GPs on occasion did reach out to System Integrators for referral support, and the Integrators would facilitate access via The Orange Door or local Centre Against Sexual Assault, and provided FDSV advice at the same time.

At the time of writing, SAPHN Consortium, TASPHN and WAPHN had not commenced collecting data on referrals.

Table 17: Nature of direct referrals to System Integrators (July 2022 to April 2025)

PHN	Total number of direct referrals	Referral nature: DFV victim-survivor	Referral nature: DFV perpetrator	Referral nature: SV victim-survivor - current	Referral nature: SV victim-survivor - historical	Referral nature: SV - perpetrator	Referral nature: CSA victim-survivor - current	Referral nature: CSA victim-survivor - historical	Referral nature: CSA - perpetrator	New	Returning
ACT	**1**	1	0	0	0	0	0	0	0	0	1
BS	**855**	837	3	13	17	0	3	12	0	672	54
CES	**44**	28	0	0	0	0	0	0	0	15	22
HNECC	**404**	402	13	1	4	0	1	0	0	103	24
NBM	**204**	174	2	11	1	0	5	9	0	168	13
NT	**3**	0	0	0	0	0	0	0	0	0	0
NWM**	**0**	0	0	0	0	0	0	0	0	0	0
SA	**0**	0	0	0	0	0	0	0	0	0	0
TAS	**0**	0	0	0	0	0	0	0	0	0	0
WA	**0**	0	0	0	0	0	0	0	0	0	0
WV**	**2**	2	0	1	1	0	0	0	0	0	2
TOTAL	**1,513**	**1,444**	**18**	**26**	**23**	**0**	**9**	**21**	**0**	**958**	**116**

* Missing data for n=439 referrals to System Integrators

** The NWMPHN and WVPHN models do not involve referrals to specialist FDSV services.

*** Referral nature can be multiples so don't add to total referrals

Table 18 summarises the characteristics of clients referred directly to the FDSV System Integrators by primary care workers in the PHNs in which referrals were made. Of the 1,513 direct referrals recorded, more than 90% were DFV victim survivors (92.8%, n=832 of 896). The remaining direct referrals were sexual violence victim-survivors (current) (2.6%, n=23 of 896), sexual violence victim-survivors (historical) (2.3%, n=21 of 896), child sexual abuse victim-survivors (historical) (2%, n=18 of 896), DFV perpetrators (1.8%, n=16 of 896), and child sexual abuse victim-survivors (current) (1%, n=9 of 896). Almost all of the individuals referred were female (96%, n=806 of 841), more than half were in their 30s and 40s (54%, n=427 of 805), and a fifth identified as Aboriginal and/or Torres Strait Islander (21%, n=167 of 808). Around a third of the individuals referred in CESPHN were from culturally and linguistically diverse backgrounds (29%, n=12 of 42) which is reflective of the demographics of that PHN.

Table 18: Characteristics of clients referred directly to System Integrators (July 2022 to April 2025)

Characteristic	---	BS	CES	HNECC	NBM	WV*	Total
---	---	(N=855)	(N=44)	(N=404)	(n=204)	(N=2)	(N=1,513)
Age (years)	Under 20	37	7	18	9	---	**71**
---	---	-5%	-23%	-5%	-5%	---	**-5%**
---	20s	149	3	76	22	---	**250**
---	---	-20%	-10%	-21%	-12%	---	**-19%**
---	30s	257	8	92	58	---	**416**
---	---	-35%	-26%	-25%	-32%	---	**-32%**
---	40s	145	9	67	42	---	**263**
---	---	-20%	-29%	-19%	-23%	---	**-20%**

Characteristic	---	BS	CES	HNECC	NBM	WV*	Total
---	---	(N=855)	(N=44)	(N=404)	(n=204)	(N=2)	(N=1,513)
---	50s	84	4	54	26	---	**168**
---	---	-11%	-13%	-15%	-14%	---	**-13%**
---	60+	61	---	54	25	---	**140**
---	---	-8%	---	-15%	-14%	---	**-11%**
---	**Total**	**733**	**31**	**361**	**182**	**0**	**1,308**
Gender	Female	741	38	363	175	2	**1,320**
---	---	-98%	-90%	-97%	-94%	-100%	**-97%**
---	Male	14	4	11	11	---	**40**
---	---	-2%	-10%	-3%	-6%	---	**-3%**
---	Other	4	---	---	---	---	**4**
---	---	0%	---	---	---	---	**0%**
---	**Total**	**759**	**42**	**374**	**186**	**2**	**1,364**
Aboriginality	Aboriginal and/or Torres Strait Islander	165	1	66	38	---	**270**
---	---	-22%	-2%	-18%	-23%	---	**-20%**
---	Neither	523	17	252	128	2	**923**
---	---	-69%	-40%	-70%	-77%	-100%	**-69%**
---	Unknown	72	24	44	1	---	**141**
---	---	-9%	-57%	-12%	-1%	---	**-11%**
---	**Total**	**760**	**42**	**362**	**167**	**2**	**1,334**
Culturally and Linguistically Diverse	Yes	136	12	27	19	2	**196**
---	---	-18%	-29%	-7%	-13%	-100%	**-15%**
---	No	503	6	295	126	---	**931**
---	---	-66%	-14%	-81%	-86%	---	**-71%**
---	Unknown	121	24	42	1	---	**188**
---	---	-16%	-57%	-12%	-1%	---	**-14%**
---	**Total**	**760**	**42**	**364**	**146**	**2**	**1,315**
Disability	Yes	52	1	32	10	---	**95**
---	---	-7%	-2%	-9%	-7%	---	**-7%**
---	No	302	11	271	130	1	**716**
---	---	-40%	-26%	-75%	-92%	-50%	**-55%**
---	Unknown	406	30	57	2	1	**496**
---	---	-53%	-71%	-16%	-1%	-50%	**-38%**
---	**Total**	**760**	**42**	**360**	**142**	**2**	**1,307**
LGBTQIA+	Yes	2	---	8	8	---	**18**
---	---	0%	---	-2%	-6%	---	**-1%**
---	No	56	20	304	134	1	**516**
---	---	-7%	-48%	-84%	-94%	-50%	**-40%**
---	Unknown	697	22	51	1	1	**772**
---	---	-92%	-52%	-14%	-1%	-50%	**-59%**

Characteristic	---	BS	CES	HNECC	NBM	WV*	Total
---	---	(N=855)	(N=44)	(N=404)	(n=204)	(N=2)	(N=1,513)
---	Total	755	42	363	143	2	1,306

Note: Data was missing for some of the direct client referrals recorded and not reported for PHNs with less than five referrals.

*The WVPHN model does not involve referrals to specialist FDSV services.

As shown in Table 19, individuals referred directly to the System Integrators for support were offered mostly specialist DFV support within the System integrator organisations, and some were offered legal support, mental health support, and housing support.

Table 19: Nature of supports provided to referred clients by the System Integrators (July 2022 to April 2025)

PHN	Total number of support occasions	Types of support offered to referred individuals by the system integrator organisations*	-	-	-	-	-	-	-	-	-
-	-	Specialist DFV service	Specialist sexual assault service	Specialist child sexual abuse service	Child protection services	Housing support	Legal support	Mental health support	Financial support	Police	Other
ACT	**4**	4	0	0	0	0	0	1	0	0	0
BS	**543**	449	9	2	0	104	107	147	19	7	14
CES	**7**	6	0	0	0	0	0	0	0	0	0
HNECC	**285**	242	3	0	3	54	68	60	23	19	13
NBM	**162**	142	2	6	4	16	32	12	12	0	5
NT	**0**	0	0	0	0	0	0	0	0	0	0
NWM**	**0**	0	0	0	0	0	0	0	0	0	0
SA	**0**	0	0	0	0	0	0	0	0	0	0
TAS	**0**	0	0	0	0	0	0	0	0	0	0
WA	**0**	0	0	0	0	0	0	0	0	0	0
WV**	**7**	7	0	0	0	1	3	0	5	1	3
TOTAL	**1,008**	**850**	**14**	**8**	**7**	**175**	**210**	**220**	**59**	**27**	**35**

* Note: Each referred individual could be offered multiple types of support so these numbers do not add up to the total number of support occasions.

** The NWMPHN and WVPHN models do not involve referrals to specialist FDSV services.

As shown in Table 20, System Integrators also made over 1,000 onward referrals to other external organisations for these clients, most often for additional specialist DFV support, mental health support, legal support and housing support.

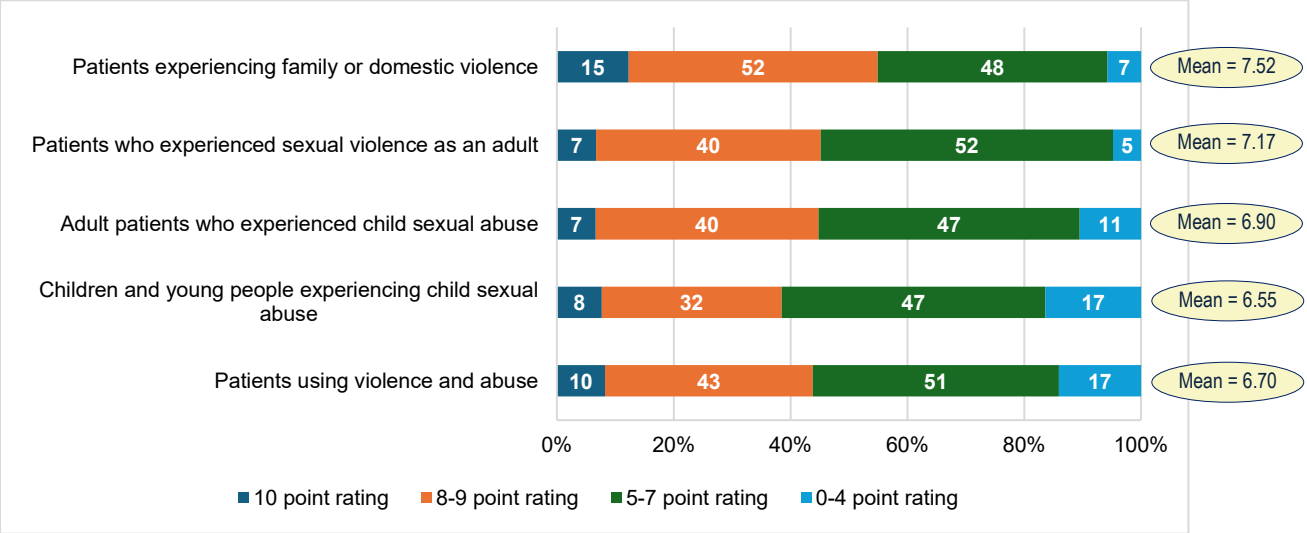
Table 20: Onward referrals provided to referred clients by the System Integrators (July 2022 to April 2025)

PHN	Total number of referrals	Referrals made by System Integrators to external support services (Warm or Cold)	-	-	-	-	-	-	-	-	-
-	-	Specialist DFV service	Specialist sexual assault service	Specialist child sexual abuse service	Child protection services	Housing support	Legal support	Mental health support	Financial support	Police	Other
ACT	**1**	0	0	0	0	0	0	1	0	0	0
BS	**531**	137	7	2	5	68	84	91	44	44	49
CES	**2**	2	0	0	0	0	0	0	0	0	0
HNECC	**333**	104	4	0	7	37	45	66	19	9	42
NBM	**174**	38	0	2	1	26	28	36	22	5	16
NT	**0**	0	0	0	0	0	0	0	0	0	0
NWM**	**0**	0	0	0	0	0	0	0	0	0	0
SA	**0**	0	0	0	0	0	0	0	0	0	0
TAS	**0**	0	0	0	0	0	0	0	0	0	0
WA	**0**	0	0	0	0	0	0	0	0	0	0
WV**	**18**	7	0	0	0	1	3	0	2	1	4
All PHNs	**1,059**	**288**	**11**	**4**	**13**	**132**	**160**	**194**	**87**	**59**	**111**

* Note: Each referred individual could be referred to multiple additional services so these numbers do not add up to the total number of referrals made by the System Integrator.
** The NWMPHN and WVPHN models do not involve referrals to specialist FDSV services.

As shown in Figure 9, follow-up survey respondents perceived the SPC Pilot had substantially enhanced the **ease with which patients experiencing FDSV and CSA, as well as patients using violence and abuse, can access the relevant support services**. Around two-fifths of all ratings were between 8 and 10, ranging from 0 being “Not at all useful” to 10 being “Very much so”, with an overall mean rating of 6.98 points across all patient groups. Survey respondents perceived the largest improvements were made to the ease with which patients experiencing family and domestic violence and patients experiencing sexual violence can access support services.

Figure 9. Follow-up survey perceptions of the extent to which the overall SPC Pilot has improved the ease with which patients experiencing FDSV and CSA can access support services



Key insights and recommendations

Summary of key insights

A whole-of-practice approach was reported to be critical for fostering culture change in practices and empowering all staff to feel responsible and confident to recognise and respond to FDSV. Similarly, System Integrators were perceived as being 'the glue', providing trusted advice, warm referrals and locally relevant referral pathways and knowledge that helped bridge the gap between primary care and specialist FDSV services.

Both interview and survey data reflect the growing awareness, knowledge and confidence among the primary care workforce in their ability to recognise and respond to FDSV. These impacts were most evident for FDV presentations (e.g., the majority of referrals were to FDV specific services). As the Pilot continues and PHNs are further along in their implementation of activities aiming to improve recognition and response to SV and CSA, it is likely these areas will see a similar improvement.

Training attendees were predominantly GPs or nurses, but participation amongst practice managers was relatively low. This finding could be because practice managers were too busy to attend, or because there were fewer practice managers to recruit for the training in each PHN (i.e., there is typically only one practice manager employed per practice, but multiple GPs and nurses).While GPs represented the largest group of training attendees in most PHNs, in NTPHN, nurses attended more sessions than any other group. This is not surprising given the over-representation of nurses, Remote Area Nurses (RANs) and AHWs in the primary care workforce in the NT, and the well-established challenges related to recruiting and retaining GPs in rural and remote areas[18].

Health practitioners consistently reported that their current referral processes to specialist FDSV services were time-consuming and not linked to their clinical software, which they perceived to be both an administrative burden and a safety risk. They also highlighted the absence of consistent feedback on whether referrals were received, actioned, or closed.

Finally, victim-survivors who identified as Aboriginal or Torres Strait Islander were disproportionately represented in the referrals to specialist FDSV services (i.e., 1/5 of all referrals). This over-representation should not be framed as a deficit, rather, it signals the SPC Pilot is providing culturally safe ways of recognising and responding to FDSV for at-risk populations.

[18] Bourke, L., Dunbar, T., & Murakami-Gold, L. (2021). Discourses within the roles of Remote Area Nurses in Northern Territory (Australia) government-run health clinics. *Health & Social Care in the Community*, *29*(5), 1401-1408.

Key recommendations

Based on these key insights and the findings of this interim evaluation, we have developed the following recommendations for consideration:

Sustainability and workforce

1. Continue providing trauma-informed FDSV training at the whole-of-practice level and ensure it is offered flexibly, delivered in short blocks of time (e.g., no longer than 2-hour per session), and scheduled well in advance to accommodate the availability and preferences of primary care staff. Flexibility is particularly important for GPs who work in smaller practices, who may experience loss of income if they need to close their practice to participate.
2. PHNs that are new to the SPC Pilot highly value the support offered by existing PHNs (e.g., the CoPs, resource sharing, networking opportunities). Ensure this continues as it is perceived to be strengthening their implementation and the activities they are delivering.
3. Encourage PHNs to communicate to GP and nurse training participant's that they can earn continuing professional development (CPD) points for completion of FDSV training, as required by the Royal Australian College of General Practitioners (RACGP) and the Nursing and Midwifery Board of Australia (NMBA).

Victim-survivor voice and outcomes

4. Embed the voice of victim-survivors in training through role playing, and, where possible, ensure training is developed and/or co-facilitated by either a GP, nurse, Aboriginal Health Worker, or a System Integrator with specialist expertise in FDSV.
5. Whilst some PHNs have co-developed training packages and resources for priority populations with organisations who advocate for the rights of these priority populations (e.g., WVPHN's Wanga Laka First Nations Family Violence program), continue to encourage other PHNs to do the same. Particularly as the referral data indicated that there is clearly a need for support amongst First Nations victim-survivors to have access to culturally safe specialist support.
6. Continue exploring opportunities to improve awareness and knowledge of FDSV areas that have traditionally been difficult to address, such as coercive control, elder abuse and child and sexual violence.

System integration and equity

7. To help close the referral 'feedback loop', consider developing standardised referral templates that can be integrated into routine practice management systems (e.g., Best Practice, MedicalDirector, Communicare), and establishing similar templates and/or processes for specialist FDSV service staff to make it easier for them to feedback to health practitioners on the outcome of their referrals. This would improve continuity of care, and ensure safer, timely follow-up for patients, particularly where child protection issues are involved.
8. Support PHNs to document clear processes and procedures related to their model, to ensure that there can be continuity of implementation and knowledge transfer should staff leave or change,

both in the PHN and their commissioned service. Support should be prioritised for PHNs servicing regional and remote areas given they are more vulnerable to recruitment challenges and high staff turnover.

9. Although there has traditionally been a focus on improving the ability of GPs to recognise and respond to FDSV, the SPC Pilot has taken a broader focus, and empowered PHNs to tailor and adapt their models so they are appropriate for the local context and needs of the populations they serve. This is clearly a strength of this Pilot, as evidenced by the model implemented in NTPHN. Ensure that this local adaptation and tailoring of the model is encouraged across all PHNs.

Appendices

Appendix 1 — Program logic model for the SPC Pilot

	Situation	Intervention *Core components and example activities*	Outcomes	
Primary Care	*Primary care staff (including GPs, practice nurses and administrative staff):* • Have not been trained to recognise and respond appropriately to FDSV, • There is a level of discomfort asking patients about FDSV (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 FDSV 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 FDSV 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 FDSV response during a consult. • Potentially different responses required for cases of family/domestic vs sexual violence affecting both adults and children.	**Core component 1: Capacity Building** *Example activities:* • Delivery of formal FDSV training for general practice-based primary care workers (clinical and administrative), • Delivery of informal FDSV capacity building for general practice-based primary care workers (clinical and administrative), • Development of practical and educational resources for use by general practice-based primary care workers (clinical and administrative). **Core component 2: System Integration** *Example activities:* • Creation of a System Integrator function that acts as a conduit between primary care and locally relevant specialist FDSV services to: – Provide ongoing support and advice to primary care on FDSV, – Provide a single referral point to local specialist FDSV services for primary care, – Provide training, support, and advice for specialist FDSV services on the role of primary care in FDSV, – Support specialist FDSV services to close the referral loop with primary care, – Improve collaboration between specialist FDSV 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 FDSV services. • Development of guidance documents, policies, and referral pathways into specialist support services for primary care. **Core component 3: Influencing the System for Sustainable Change** *Example activities* • PHN advocacy for increased, consistent funding of the specialist FDSV sector • Co-locating the Linker/Connector role across primary care and specialist FDSV services, • Interdisciplinary Communities of Practice and networking events between primary care and the specialist FDSV sector • Advocating for better integration between primary care and specialist FDSV sector • Mentoring provided by BSPHN.	Primary care staff have: • Improved **readiness** to address FDSV: – *FDSV awareness, confidence, and capacity to recognise, ask about, respond, and refer.* • Improved **understanding** of the role of specialist FDSV services in supporting victim-survivors • An increased number of GPs **recognising** FDSV. • An increased **number of GP referrals** to local specialist FDSV services.	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.
Specialist FDSV Services	*Specialist FDSV Services working with victim-survivors of FDSV:* • 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.		Specialist FDSV services have: • Improved **understanding** of the role of primary care in supporting victim-survivors • An increased **number of victim-survivors attending their services** because of GP referrals. • Increased the number of 'closed referrals.'	
Victim-survivors	*Victim-survivors of FDSV:* • Are not aware of FDSV 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).		Victim-survivors have: • Increased **awareness** of support services available and how to navigate them. • Increased **comfort** to discuss partner abuse with GP. • Increased **access** to FDSV services/supports.	

Appendix 2 — Key evaluation questions & sub-questions

Key Evaluation Question (questions in grey will be addressed in the final evaluation report)	Aim 1	Aim 2	Aim 3
1. What activities were implemented across the three components?	✓		
2. How well was the Pilot implemented across 12 PHNs?	✓	✓	
a) Did it effectively engage a broad range of primary care staff and FDSV service staff?	✓	✓	
b) Did it effectively engage whole practices/ services (including both practitioners and administrative staff)?	✓	✓	
c) Did it effectively deliver a range of appropriate and locally tailored FDSV-related training, resources and capability building activities?	✓	✓	
d) Did the approach align with clinical advice outlined in the RACGP's *Abuse and Violence – Working with our Patients in General Practice* (White Book, 5th Ed), and were there any gaps?			
e) Did the training align with other Federally-funded training that health practitioners received e.g., Monash course in recognising and responding to sexual violence?			
f) Did it deliver appropriate post-training support to assist practices/ services to identify and respond to FDSV victim-survivors?	✓	✓	
g) Did it result in locally relevant care and referral pathways for people experiencing, or at risk of, FDSV?	✓	✓	✓
h) Were appropriate feedback loops between FDSV services and primary care practices/ services established?	✓	✓	✓
i) Did it result in the integration of primary care into local FDSV support systems (including clear roles for GPs within this system)?	✓	✓	✓
j) How did it overcome the barriers to FDSV victim-survivor disclosure?		✓	✓
k) Did FDSV victim-survivors receive more coordinated support?		✓	✓

3. What were the barriers and facilitators of the SPC Pilot's implementation?		✓	
a) What barriers and facilitators were experienced by FDSV victim-survivors when presenting and disclosing FDSV to their health practitioner?		✓	
b) What barriers and facilitators were experienced by primary care and FDSV support service staff engaging with the SPC Pilot, at both the practice/service and system levels?		✓	
c) How successfully did primary care practices/services and FDSV support services address any barriers encountered?		✓	
4. How acceptable was the SPC Pilot?		✓	
a) How well did the SPC Pilot meet the needs of the primary care workforce and FDSV support service staff?		✓	
b) How well did the Pilot meet the needs of FDSV victim-survivors?			
5. Did the SPC Pilot achieve its intended outcomes?			✓
a) Did it improve the primary care workforce's awareness, ability and confidence to recognise and respond to FDSV?			✓
b) Did it contribute to an increase in primary care sector referrals to specialist FDSV support services?			✓
c) Did it improve specialist FDSV support services' understanding of the role of primary care in supporting FDSV victim-survivors?			✓
d) Did it contribute to improving relationships and collaboration between the primary care and FDSV sectors towards a more coordinated approach to supporting FDSV victim-survivors?			✓
e) Did it improve FDSV victim-survivors' experiences and outcomes of receiving support?			
6. Was the SPC Pilot's impact equitably distributed across participant sub-groups?			
a) Were any FDSV implementation activities, system-level, PHN site, primary care services, FDSV service or participant characteristics associated with larger improvements in outcomes 1a-e above?			
b) Were any improvements in FDSV victim-survivors' experiences and outcomes equitably distributed across all victim-survivor sub-groups (e.g. Aboriginal, LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual) and culturally and linguistically diverse (CALD) communities)?			

Appendix 3 — FDSV episodic baseline survey

Welcome to the **Baseline Survey for the Family, Domestic and Sexual Violence (FDSV) Pilot** initiative currently underway through selected Primary Health Networks (PHNs) across all states and territories of Australia. This federally-funded initiative is an action under the National Plan to End Violence against Women and Children 2022-2032 and continues and expands the work of a previously funded similar initiative focused exclusively on Family and domestic violence.

Over the next couple of years, **PHNs will be rolling out a range of resources, training and other capacity building opportunities to support the primary care workforce to better recognise and respond to patients experiencing family, domestic and/or sexual violence (including child sexual abuse)**. Primary Care practices and services will also **have access to dedicated specialist FDSV support workers** (variously referred to as Local Links, Linkers, Link Workers, Connectors, Navigators or Family Violence Workers in the different jurisdictions) for more detailed and localised advice and support in managing and/or referring any patients experiencing, or at risk of, family, domestic and sexual violence (including child sexual abuse).

The FDSV Pilot will be implemented differently in each region, tailored to local needs and preferences - so **your practice/service might be offered training and support relating to the various topic areas (family & domestic violence, sexual violence and child sexual abuse) at different points in time**. As this baseline survey is part of the national evaluation of the overall FDSV Pilot it includes questions in relation to each of the topic areas - your ratings here will be used as a baseline against which we can compare later ratings to help us understand how well the FDSV Pilot contributes to improving the primary care sector's ability to recognise and respond to all these different aspects of FDSV.

This survey is voluntary and should take **only about 5 minutes to complete**. It is an important part of the data being collected about the impact of the FDSV Pilot, so we would really appreciate you taking the time to participate. Your responses will be anonymous and will be grouped, analysed and presented in an Evaluation Report for the Department of Health & Aged Care (DoHAC). We will ensure that no individuals or services are identifiable. Once endorsed by DoHAC, this report will be shared with participating PHNs and FDSV services and will also be available on request from the Evaluation Team (see contact details below). We have received ethics approval for this project from the Human Research Ethics Committee (HREC) at the UNSW.

You may also receive invitations to complete a similar survey as the FDSV Pilot progresses - likely in about 3-6, 12 and 18 months.

If you would like to participate in this survey, please click on the 'Yes - I agree' button below and the survey questions will appear straight away.

Q1.1 **Are you happy to continue with this baseline survey?**

Yes (1)
No (2)

Skip To: End of Survey If Q1.1 = No

Q2.1 To help us link your responses across surveys, please provide the **first three letters of your surname** and the **last three numbers of your mobile phone number** (eg: ABC123).

FIRST three letters of your surname (1) _____
LAST three numbers of your mobile phone number (3) _____

Q2.2 Which best describes your practice/service?

Multi-GP Practice (2-5 GPs) (1)
Multi-GP Practice (6-10 GPs) (2)
Multi-GP Practice (11+ GPs) (3)
Solo GP (4)
Allied Health Service (5)
Aboriginal Medical Service (AMS) (6)
Other ACCHO (7)
Dental service (8)
Local Health District (LHD) - ***please specify which Department***: (9)
_____
Pharmacy (10)
Psychology service (11) Reframed as Mental health service
Other - *please specify*: (12) _____
Code 13 = Community-based support service
Code 14 = Legal service
Code 15 = Private medical specialist

Q2.3 Which best describes your MAIN role within the practice/service?

Clinician or practitioner (providing direct clinical care for patients) (1)
Practice / Service manager (2)
Administrative (eg: receptionist, clerk) (3)

Display this question: If Q2.3 = Clinician or practitioner (providing direct clinical care for patients)

Q2.4 What is your profession?

Aboriginal Health Practitioner (1)
Aboriginal Health Worker (2)
Community Health Worker (3) Include Care & Case Coordinators
Dentist (4)
GP (5) Include GP registrars
Nurse / CNC (6)
Occupational therapist (7)
Pharmacist (8)
Physiotherapist (9) Reframed as Physical therapist (to include Osteos, Chiros, etc)
Psychologist (10) Reframed as Mental health practitioner (to include counsellors, psychiatrists, music/art/play therapists, peer/LE workers, etc)
Speech therapist (11)
Other: *please specify* (12) _____
Code 13 = Social worker / Youth worker
Code 14 = Legal professional
Code 15 = Medical specialist

Display this question: If Q2.3 = Clinician or practitioner (providing direct clinical care for patients)

Q2.5 How long have you been practising in this profession (in any practice/service)?

1 - 5 years (1)
6 - 10 years (2)
11 - 20 years (3)
> 20 years (4)

Q2.6 In which state or territory is your practice/service based?

ACT (1)
NSW (2)
NT (3)
QLD (4)
SA (5)
TAS (6)

VIC (7)
WA (8)

Display this question: If Q2.6 = NSW Or Q2.6 = VIC Or Q2.6 = SA

Q2.7 In which of these PHNs is your practice/service based?

Adelaide PHN (7)
Central and Eastern Sydney PHN (1)
Country South Australia PHN (8)
Hunter New England and Central Coast PHN (2)
Nepean Blue Mountains PHN (3)
North Western Melbourne PHN (4)
Western Victoria PHN (5)
Don't know / unsure (6)

Display this question: If Q2.7 = Don't know / unsure

Q2.8 What is the postcode where your practice/service is based?

_____

Display this question: If Q2.6 = NSW Or Q2.6 = VIC Or Q2.6 = QLD

Q2.9 Your local PHN began supporting the primary care sector to improve their response to domestic and family violence (DFV) in 2019 - by providing training, resources and access to a DFV support worker. This work is now being expanded to also support improvements in the primary care sector's response to sexual violence and child sexual abuse. **To the best of your knowledge, was your practice receiving support through this initiative before 2023?**

Yes (1)
No (2)
Unsure (3)

Q2.10 Have you received any training in relation to recognising and responding to family, domestic and/or sexual violence?

Please select as many as apply

⊗No, none (1)
Yes, during my professional training (2)
Yes, during my current role in this practice/service (3)
Yes, during previous roles elsewhere (4)

Q3.1 How would you describe your involvement to date (if any) with the current initiative aimed at building primary sector capability in relation to family, domestic and/or sexual violence?

None yet (1)
Minimal (eg: initial contacts with the FDSV support worker only) (2)
Moderate (eg: attended training) (3)
Major (eg: received support with individual patients or made referrals) (4)

Q4.1 Family, domestic and sexual violence (FDSV) is a major health and welfare issue in Australia, occurring across all socioeconomic and demographic groups, but predominantly affecting women and children. Family & domestic violence occurs within family relationships, such as between parents and children, siblings, intimate partners (or former partners) or kinship relationships. It includes physical and/or sexual violence, emotional abuse and coercive control. Sexual violence can take many forms, including sexual assault, sexual threat, sexual harassment, child sexual abuse, and image-based abuse -

it can occur within or outside families. **To what extent do you agree that the primary care sector has a role to play in … ??**

	Not at all 0	1	2	3	Somewhat 4	5	6	Totally agree 7	8	9	10	Don't know
Identifying & supporting patients experiencing family and domestic violence ()												
Identifying & supporting patients having experienced sexual violence as an adult ()												
Identifying & supporting adult patients having experienced child sexual abuse ()												
Identifying & supporting children and young people experiencing child sexual abuse ()												
Working safely & effectively with patients using violence & abuse as part of a broader system of accountability ()												

Q4.2 **And how familiar are you with relevant guidelines, legislation and policies about the primary care sector's responsibilities in relation to … ?**

	Not at all 0	1	2	3	OK but could be better 4	5	6	Extremely familiar 7	8	9	10	Don't know
Patients experiencing family and domestic violence ()												
Patients having experienced sexual violence as an adult ()												
Adult patients having experienced child sexual abuse ()												
Children and young people experiencing child sexual abuse ()												
Patients using violence & abuse ()												

Q4.3 **And how confident do you currently feel about your ability to IDENTIFY ... ?**

	Not at all 0	1	2	3	OK but could be better 4	5	6	Extremely confident 7	8	9	10	Don't know
Patients experiencing family and domestic violence ()												
Patients having experienced sexual violence as an adult ()												
Adult patients having experienced child sexual abuse ()												
Children and young people experiencing child sexual abuse ()												
Patients using violence & abuse ()												

Q4.4 **And how confident do you currently feel about your ability to RESPOND APPROPRIATELY to ... ?**
Drag the red button to your preferred ratings.

	Not at all			OK but could be better			Extremely confident			Don't know
	0	1	2	3	4	5	6	7	8	9	10
Patients experiencing family and domestic violence ()											
Patients having experienced sexual violence as an adult ()											
Adult patients having experienced child sexual abuse ()											
Children and young people experiencing child sexual abuse ()											
Patients using violence & abuse ()											

Q4.5 What type of supports would best help you to improve your ability to identify and respond appropriately to patients experiencing family, domestic or sexual violence and/or patients using violence & abuse?

_____

Q5.1 **Finally, a few questions to help us group your answers.**
Which age group do you fit into?

Less than 20 years (1)
20s (2)
30s (3)
40s (4)
50s (5)
60+ years (6)
Prefer not to say (7)

Q5.2 Which gender do you identify with?

Female (1)
Male (2)
Non-binary/ Other (3)
Prefer not to say (4)

Q5.3 Which best describes the area where you work?

Metropolitan (capital city areas) (1)
Regional (non-capital cities and surrounding areas) (2)
Rural (country towns and surrounding areas) (3)
Remote (places relatively far from a town and/or with minimal access to services) (4)

Q5.4 Do you identify as Aboriginal and/or Torres Strait Islander?

Yes (1)
No (2)
Prefer not to say (3)

Q5.5 Do you speak a language other than English at home?

No, only English (1)
Yes - *please specify:* (2) _____

Q5.6 Please indicate the name of your practice/service. *This information will be used to help us link the overall survey data with monitoring information being collected about the support provided to each practice/service through the Pilot. Your*

responses will still be kept confidential and you or your practice/service will not be identified in our analyses or reporting.

Q24 This is the final question. Thank you for completing this survey.

Appendix 4 — FDSV episodic follow-up survey

Welcome to the Followup Survey for the **Family, Domestic and Sexual Violence (FDSV) Pilot initiative** currently underway through selected Primary Health Networks (PHNs) across all states and territories of Australia. This federally-funded initiative is an action under the National Plan to End Violence against Women and Children 2022-2032 and continues and expands the work of a previously funded similar intiative focussed exclusively on Family and domestic violence.

Between 2023 and 2026, **PHNs are rolling out a range of resources, training and other capacity building opportunities to support the primary care workforce to better recognise and respond to patients experiencing family, domestic and/or sexual violence (including child sexual abuse)**. Primary Care practices and services will also have access to dedicated specialist FDSV support workers (variously referred to as Local Links, Linkers, Link workers, Connectors, Navigators or Family Violence Workers in the different jurisdictions). These FDSV support workers are able to provide more detailed and localised advice and support in managing and/or referring any patients experiencing, or at risk of, family, domestic and sexual violence (including child sexual abuse).

The FDSV Pilot is being implemented differently in each region, tailored to local needs and preferences - so your practice/service might be offered training and support relating to some or all of the topic areas (family & domestic violence, sexual violence and child sexual abuse) at different points in time. As this followup survey is part of the national evaluation of the overall FDSV Pilot it includes some questions in relation to each of the topic areas to help us understand how well the FDSV Pilot contributes to improving the primary care sector's ability to recognise and respond to all these different aspects of FDSV.

This survey is voluntary and should take about 15 minutes to complete. It is an important part of the data being collected about the impact of the FDSV Pilot, so we would really appreciate you taking the time to participate. Your responses will be anonymous and will be grouped, analysed and presented in an Evaluation Report for the Department of Health & Aged Care (DoHAC). We will ensure that no individuals or services are identifiable. Once endorsed by DoHAC, this report will be shared with participating PHNs and FDSV services and will also be available on request from the Evaluation Team (see contact details below). We are seeking ethical approval for this project from the Human Research Ethics Committee at the UNSW. You may also receive invitations to complete a similar survey as the FDSV Pilot progresses - likely in another 6 and/or 12 months.

If you're happy to participate in this survey, please click on the 'Yes' button below and the survey questions will appear straight away.

If you would like more information before deciding, please click on the button below that says 'I'd like to read the Participant Information Statement'. You will then be given the choice to click on the 'Yes' button or the 'No' button once you have read the full information in that statement.

Q1.1 **Are you happy to continue with this followup survey?**

Yes (1)
No (2)
I'd like to read the Participant Information Statement (3)

Skip To: End of Survey If Q1.1 = No

Display this question: If Q1.1 = I'd like to read the Participant Information Statement

Q1.2 **Do you agree to continue with the survey?**

Yes, I agree (1)
No, I do not agree (2)

Skip To: End of Survey If Q1.2 = No, I do not agree

Q1.3 To help us link your responses across surveys, please provide the **first three letters of your surname** and the **last three numbers of your mobile phone number** (eg: ABC123).

FIRST three letters of your surname (1) _____
LAST three numbers of your mobile phone number (3) _____

Q1.4 Which best describes your practice/service?

Multi-GP Practice (2-5 GPs) (1)
Multi-GP Practice (6-10 GPs) (2)
Multi-GP Practice (11+ GPs) (3)
Solo GP (4)
Allied Health Service (5)
Aboriginal Medical Service (AMS) (6)
Other ACCHO (7)
Dental service (8)
Local Health District (LHD) - ***please specify which Department***: (9) _____
Pharmacy (10)
Psychology service (11) Reframed as Mental health service
Other - *please specify*: (12) _____
Code 13 = Community-based support service
Code 14 = Legal service
Code 15 = Private medical specialist
Code 16 = Sexual Health Centre – for NBMPHN surveys
Code 17 = Community Health Centre – for WVPHN surveys
Code 19 = General Practice (size unknown) – for WVPHN surveys

Q1.5 Which best describes your MAIN role within the practice/service?

Clinician or practitioner (providing direct clinical care for patients) (1)
Practice / Service manager (2)
Administrative (eg: receptionist, clerk) (3)

Display this question: If Q1.5 = Clinician or practitioner (providing direct clinical care for patients)

Q1.6 What is your profession?

Aboriginal Health Practitioner (1)
Aboriginal Health Worker (2)
Community Health Worker (3) Include Care & Case Coordinators
Dentist (4)
GP (5) Include GP registrars
Nurse / CNC (6)
Occupational therapist (7)
Pharmacist (8)
Physiotherapist (9) Reframed as Physical therapist (to include Osteos, Chiros, etc)
Psychologist (10) Reframed as Mental health practitioner (to include counsellors, psychiatrists, music/art/play therapists, peer/LE workers, etc)
Speech therapist (11)
Other: *please specify* (12) _____
Code 13 = Social worker / Youth worker
Code 14 = Legal professional
Code 15 = Medical specialist
Code 19 = Allied health professional (NFI) – for WVPHN surveys

Display this question: If Q1.5 = Clinician or practitioner (providing direct clinical care for patients)

Q1.7 How long have you been practising in this profession (in any practice/service)?

1 - 5 years (1)
6 - 10 years (2)
11 - 20 years (3)

> 20 years (4)

Q1.8 In which state or territory is your practice/service based?

ACT (1)
NSW (2)
NT (3)
QLD (4)
SA (5)
TAS (6)
VIC (7)
WA (8)

Display this question: If Q1.8 = NSW Or Q1.8 = VIC Or Q1.8 = SA

Q1.9 In which of these PHNs is your practice/service based?

Adelaide PHN (1)
Central and Eastern Sydney PHN (2)
Country South Australia PHN (3)
Hunter New England and Central Coast PHN (4)
Nepean Blue Mountains PHN (5)
North Western Melbourne PHN (6)
Western Victoria PHN (7)
Don't know / unsure (8)

Display this question: If Q1.9 = Don't know / unsure

Q1.10 What is the postcode where your practice/service is based?

_____

Q2.1 **To what extent do you agree that the primary care sector has a role to play in … ??**

	Not at all 0	1	2	3	**Somewhat** 4	5	**Totally agree** 6	7	8	9	Don't know 10
Identifying & supporting patients experiencing family and domestic violence ()											
Identifying & supporting patients having experienced sexual violence as an adult ()											
Identifying & supporting adult patients having experienced child sexual abuse ()											
Identifying & supporting children and young people experiencing child sexual abuse ()											
Working safely & effectively with patients using violence & abuse as part of a broader system of accountability ()											

Q2.2 **And how familiar are you with relevant guidelines, legislation and policies about the primary care sector's responsibilities in relation to … ?**

	Not at all 0	1	2	3	**OK but could be better** 4	5	6	**Extremely familiar** 7	8	9	Don't know 10
Patients experiencing family and domestic violence ()											
Patients having experienced sexual violence as an adult ()											
Adult patients having experienced child sexual abuse ()											
Children and young people experiencing child sexual abuse ()											
Patients using violence & abuse ()											

Q2.3 **And how confident do you currently feel about your ability to IDENTIFY ... ?**

	Not at all 0	1	2	3	OK but could be better 4	5	6	Extremely confident 7	8	9	10	Don't know
Patients experiencing family and domestic violence ()												
Patients having experienced sexual violence as an adult ()												
Adult patients having experienced child sexual abuse ()												
Children and young people experiencing child sexual abuse ()												
Patients using violence & abuse ()												

Q2.4 **And how confident do you currently feel about your ability to RESPOND APPROPRIATELY to ... ?**

	Not at all 0	1	2	3	OK but could be better 4	5	6	Extremely confident 7	8	9	10	Don't know
Patients experiencing family and domestic violence ()												
Patients having experienced sexual violence as an adult ()												
Adult patients having experienced child sexual abuse ()												
Children and young people experiencing child sexual abuse ()												
Patients using violence & abuse ()												

Q3.1 Have you engaged with the FDSV Initiative in any of the following ways? *Please select a response for each item.*

	Yes (1)	Maybe (2)	No (3)
Attended training events relating to DFV, sexual violence or child sexual abuse organised by your local PHN or FDSV support worker (3)			
Accessed resources relating to DFV, sexual violence or child sexual abuse distributed by your local PHN or FDSV support worker (eg: RACGP White Book, HealthPathways, FDSV-related posters, flyers, checklists, tools, links to webinars & external resources) (1)			
Participated in Quality Improvement or Capability Building activities relating to DFV, sexual violence or child sexual abuse (eg: Community of Practice, networking events, workshops, Practice consults, QI toolkit, PDSA cycles) (2)			
Received advice or support from your local FDSV support workers (eg: with general information, referral advice or pathways, case consultations) - you may know them as a Local Link, Linker, Connector or FV worker (18)			
Referred any of your patients to the local FDSV support workers - you may know them as a Local Link, Linker, Connector, Integrator or FV worker (21)			

Skip To: End of Survey If Q3.1 [No] (Count) = 5

Q4.1 Which FDSV-related training(s) have you attended? *Please select as many as apply. (ONLY site-relevant trainings are displayed to respondents)*

A Trauma-informed Primary Health Care Response to Child Sexual Abuse: Recognise, Respond, and Refer (35)
A Trauma-informed Primary Health Care Response to DFV: Recognise, Respond, and Refer (36)

A Trauma-informed Primary Health Care Response to Sexual Violence: Recognise, Respond, and Refer (37)
Being a trauma-informed general practice (for administrators and managers) (3)
Blueknot Safety & Stabilisation Training (57)
Child Protection & DFSV (65)
Child Sexual Abuse: A whole practice approach (38)
Child sexual abuse training (4)
Child, Youth and Family Intervention (58)
Complex Trauma Foundational (59)
CSA A-LIVES - Child Sexual Abuse Clinical Session (46)
CSA Online Webinar (54)
Cultural considerations in responding to violence and abuse (5)
Culturally appropriate care for Aboriginal patients impacted by violence or abuse (31)
DFSV Fundamentals (40)
DFSV Fundamentals (Central Australia & Barkly region) (66)
DFV Combined Training (6)
DFV Foundational training (7)
DFV in the context of culture & identity: Aboriginal and Torres Strait Islander Peoples (8)
DFV in the context of culture & identity: Culturally and Linguistically Diverse Peoples (9)
DFV in the context of culture & identity: LGBTIQ+ Communities (10)
DFV in the context of culture & identity: People with a disability (11)
DFV Level 1 (12)
DFV Level 2 (13)
DFV – Next Steps (14)
Documenting & recording DFSV (67)
DV Alert (60)
Effects of DFV on children and youth (52)
FDSV & Child Sexual Abuse Online Webinar (55)
FDSV A-LIVES - Clinical Session (48)
FDSV A-LIVES - Combined Clinical and Non-Clinical Session (50)
FDSV A-LIVES - Non-Clinical Session (49)
FDSV Online Webinar (56)
Forensic Nursing (61)
Honor based violence in CALD Communities (43)
Identifying & managing DFSV-related vicarious trauma (68)
Immediate Safety Planning (69)
Information Sharing & Documentation (15)
Introduction to DFV training (16)
Introduction to Risk Assessment & Management (70)
Management of non-fatal strangulation (53)
Managing Wellbeing and Recognising Violence (62)
Mandatory Reporting (71)
Medical & Forensic Management of Adult Sexual Assault (63)
Motivational interviewing (44)
Non-Fatal Strangulation (17)
NT Sexual Assault Referral Centre (SARC) 101 (41)
Pathways to Safety program (18)
Practice Portal webinars (19)
Recognise and respond to family violence (29)
Recognise Respond Refer Foundational Training: An Integrated Health Care Response to DFV, sexual assault & child sexual abuse (20)
Recognise Respond Refer: Spotlight on Coercive Control (21)
Recognising and Responding to Sexual Violence in Adults (42)
Responding to DFV in Primary Care (22)
Responding to sexual assault and understanding the forensic process. (What GPs can do to support forensics) (45)
Sexual Violence: A whole practice approach (39)
Sexual violence training (23)
Sexual Violence / Child Sexual Abuse Combined training (24)
Strengthening Clinical Practices to Safeguard Adults Vulnerable to Abuse in Their Family, Home and Community (25)

Strengths-based clinical documentation and mandatory reporting - supporting safe parenting, and accountability for PUV (26)
Trauma Focused ACT (64)
Trauma-informed approaches to DFSV Screening (72)
Trauma-informed care for clinicians (27)
Understanding and responding to adult survivors of child sexual abuse (28)
Understanding and responding to Intimate Partner Violence/ reproductive coercion (30)
Wanga Laka Family Violence Workshop (51)
Working with people who use violence (32)
Other - please *specify:* (33) _____

⊗None of these (34)

Q4.2 How would you rate the training(s) you attended in relation to ... ? *Please select 2 ratings for each training. Ratings were sought for each Training indicated as attended at Q4.1*

	The quality of the training*(0=Terrible... 5=OK/ It varied ... 10=Excellent)*											**The relevance of the training for your work role***(0=Terrible... 5=OK/ It varied ... 10=Excellent)*										
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

Q4.3 Have you been able to apply what you learned in the training(s) in your work?

No, I haven't had an opportunity (1)
No, I wasn't comfortable to (2)
Yes, once or twice (3)
Yes, a few times (4)
Yes, many times (5)

Q4.4 Could you please give an example of how you've applied the training in your work.

_____

Q5.1 Which FDSV-related resource(s) have you used? *Please select as many as apply. (ONLY site-relevant resources are displayed to respondents)*

5As Counselling Model (136)
ACT Risk Assessment and Management Framework Factsheet 5 - ACT Key Risk Factors (72)
Adolescent FV in the home (137)
AJGP - Non-Fatal Strangulation (109)
ANROWS Factsheet - Experiences of violence (73)
Business Cards (option DISABLED) (4)
Care and Connect flyer (5)
CAWLS Animated resource (128)
CAWLS MR Flowcharts (129)
CAWLS Training handout (130)
CAWLS video resource (131)
CESPHN DFV Pens/ Fridge magnets (6)
Charmed and Dangerous (7)
Child Sexual Abuse Link Worker Business Cards (101)
Children Affected by Family Violence (8)
'Clinical Audit Pathways to Safety' spreadsheet (9)
Coercive Control cards (10)
Coercive Control Waiting Room Poster (11)
Common Risk and Safety Framework (CRASF) (12)
CRARMF tools (Common Risk Assessment and Risk Management Framework) (14)
CRCC Link Worker business cards (107)
CSA A-LIVES Resources Pack (includes ALL resources) (110)
CSA Definition (111)

CSA HealthPathways Flyer (112)
CSA Mandatory reporting laws (113)
CSA Presentations (114)
CSA Recording (115)
CSA References and Resources (116)
CSA Referral options (117)
CSA Statistics (118)
CSA Validating Statements (119)
Cycle of Violence Images (78)
DFSV/Child Sexual Abuse Posters (15)
DFSV Service Directory (102)
DFV Link Worker Business Cards (88)
DFV poster (covert) for women's bathroom spaces (85)
DFV Resources and Support Services Directory (16)
DFV Risk Indicators & Safety Planning Strategies Guide (83)
DFV Start the Conversation Guide (17)
DFV Training Flyer (18)
Do No Harm booklet (80)
DSWB stickers (69)
Eastern Suburbs DV Network Cards (19)
Enhancing Safety (20)
Equity Wheel poster (79)
Factsheet: How to make a child protection report (104)
Family Safety Pack (Australian Govt DSS) (21)
FDSV A-LIVES Overview (1)
FDSV A-LIVES Resources Pack (includes ALL resources) (2)
FDSV Action Plan (24)
FDSV At Risk Groups (3)
FDSV Compendium (132)
FDSV Confidentiality & Reporting (13)
FDSV Definitions (22)
FDSV Health Effects & Presentations (30)
FDSV HealthPathways Flyer (32)
FDSV High Risk Indicators (33)
FDSV Link Worker Referral Form (89)
FDSV Pocket Guide (25)
FDSV Recording (120)
FDSV References and Resources (52)
FDSV Referral Options (53)
FDSV Statistics (23)
FDSV Validating Statements (62)
Flowchart on referring to the DFV link worker (106)
Foreign language FV resources (138)
GP Family Violence Information Pack (133)
Guide to the DFV GP Action Plan (26)
Hand sanitisers (covert resource to support engagement) (27)
Healthy Relationships Book (28)
He doesn't hit you but he ...' poster (29)
HealthPathways (31)
HealthPathways Sticker (71)
HNECC DFSV Online Toolkit (70)
Identifying and Responding to Domestic and Family Violence e-learning module (34)
Improving Understanding - CSA Perpetrators (121)
Improving Understanding - CSA Victim-Survivors (122)
Indigenous Family Violence resources (134)
Information Sharing Guidelines (35)
Information Sharing Schemes - CISS and FVISS (123)
Information sheet on referring to the DFV link worker (90)

Information sheet on referring to the CRCC link worker (127)
Interagency Information Sharing Service (36)
It's Not Just Physical resource (82)
Know the Steps Tearoom Poster (37)
Local link flyer & brochure (105)
Managing Non-Fatal Strangulation in Primary Care (87)
MARAM Framework (38)
Men's Wellbeing Guides (39)
Myth buster cards (40)
Myth buster posters (41)
Navigator business cards (42)
Non-lethal strangulation information card (43)
Orange Door Brochure & Referral form (135)
Overview of FDSV program (108)
Pathways to Safety Participant handbook (44)
Power and Control Wheel poster (46)
PowerPoint slides from DFV foundational training (92)
Practice readiness checklist (47)
Provide Support for CSA (124)
Provide Support for FDSV (48)
Questioning Technique – CSA Sensitive enquiry (125)
Questioning Technique – FDSV Sensitive enquiry (49)
Quick phone guide for women and families (50)
RACGP - AJGP Article - 'I thought I was about to die': Management of non-fatal strangulation in general practice and family violence in general practice (75)
RACGP - AJGP Article - Recognising and responding to domestic and family violence in general practice (74)
RACGP White Book (51)
Recovering from adult sexual assault booklet (98)
Relationships Australia resource bag (54)
Resource Card (55)
Responding to Child Sexual Abuse: Referral pathway flowchart (93)
Responding to DFV: Referral pathway flowchart (91)
Responding to non-fatal strangulation, sexual choking & brain injury (99)
Responding to Sexual Violence: Referral pathway flowchart (95)
Role Play Video (GP and DFV victim-survivor) (96)
Role Play Video (GP and Person Using Violence) (97)
Safer Options IPV (Intimate Partner Violence) posters and flyer (56)
Sexual Violence Link Worker Business Cards (100)
Start the Conversation(short video) (57)
Strangulation in Intimate Partner Violence Fact Sheet (58)
Strangulation Management resources (86)
Strengthening GP responses to child sexual abuse in primary health care (NCACSA Practice tool) (59)
Strengthening GP responses to sexual violence in primary health care (NCACSA Practice tool) (60)
Subpoena Survival Guide (61)
The Age of Sexual Consent - Victoria (126)
Wanga Laka First Nations Family Violence Workshop Booklet (103)
WDVCAS cards (63)
We Are Here To Support You poster (84)
Working with CALD women resource (64)
Working with FDSV Perpetrators (65)
Working with victims and survivors of child sexual abuse and sexual violence (NCACSA video) (66)
Other - *please specify:* (67) _____

⊗None of these (68)

Q5.2 How useful have you found the resource(s) in your work? *Please drag the red button to your preferred rating for each resource. Ratings were sought for each Resource indicated as used at Q5.1*

Not at all				Somewhat				Extremely		
0	1	2	3	4	5	6	7	8	9	10

Q5.3 Any comments or feedback you'd like to provide about the resource(s) you've used?

_____

Q6.1 Which FDSV-related quality improvement or capability building activity(s) did you participate in? *Please select as many as apply. (ONLY site-relevant QI/CB activities are displayed to respondents)*

"Adapt and Adopt" workshop (1)
Child Sexual Abuse Community of Practice (2)
Child Sexual Abuse Foundations (46)
CPD Dinner - Medico-legal considerations (3)
CPD Dinner - Personal and practice sustainability (4)
DFSV QI Toolkit (6)
DFV Community of Practice (5)
DFV Foundations (43)
Education and Networking Dinner "A whole of community approach to ending DFV". (7)
Education and Networking Dinner "A whole of community approach to ending sexual violence and child sexual abuse". (8)
FDSV Community of Practice for FDSV Links (9)
FDSV Community of Practice for GPs (10)
FDSV Final Practice Consult (30)
Final Practice Consult - F2F (option DISABLED) (13)
Final Practice Consult - online (option DISABLED) (14)
FDSV Initial Practice Consult (29)
FDSV Practice Quality Improvement Consults (21)
FDSV Workforce Capacity Building Grants (25)
Governance Review (Policy/Procedure) (33)
Governance Review (Report) (34)
Governance Support (35)
Initial Practice Consult - F2F (option DISABLED) (11)
Initial Practice Consult - online (option DISABLED) (12)
Innovation workshops with general practices and FDSV service providers (15)
Integrated Care CPD Activities (16)
Lived Experience Advisory Group (26)
Networking events for General practices & FDSV services (17)
Partner Briefing / Working Group Meeting (38)
PDSA - Identifying patients at risk of FDSV (18)
PDSA - Implementing FDSV screening tool for indicated patients (19)
PDSA - Trauma-informed reception experience (20)
Primary Care Family & Sexual Violence Foundations (44)
Primary Care Workforce Advisory Group (27)
Remote Primary Care Workforce Advisory Group (41)
SARC Sexual Assault Referral Services CPD Event (31)
Sexual Violence & Sexual Assault Foundations (45)
Sexual Violence Community of Practice (22)
Staff surveys (42)
Stop DV Conference (32)
Training & Resources Needs Assessment (28)
Other - *please specify:* (23) _____

⊗None of these (24)

Q6.2 How useful have these activity(s) been in your work? *Please drag the red button to your preferred rating for each activity.* *Ratings were sought for each QI/CB activity indicated as participated in at Q6.1*

Not at all				Somewhat				Extremely		
0	1	2	3	4	5	6	7	8	9	10

Q6.3 Any comments or feedback you'd like to provide about the activity(s) you've participated in?

_____

Q7.1 **The following questions ask about your experience of the dedicated FDSV support workers recruited as part of this Initiative (you may know them as a Local Link, Linker, Connector or FV worker).** In the last 6 months, how often have you received the following types of support from one of the FDSV support workers? *Please select 1 rating for each support type* *Items with a * were asked only of Clinicians*

	Never (0)	**Once or twice** (1)	**3-5 times** (2)	**6+ times** (3)
General advice about supporting patients having experienced family, domestic or sexual violence (including child sexual abuse) (16)				
* Advice about specific patients at risk of or experiencing **family or domestic violence** (eg: case consultations, referral advice) (17)				
* Advice about specific patients having experienced **sexual violence** (eg: case consultations, referral advice) (18)				
* Advice about specific patients having experienced **child sexual abuse** (eg: case consultations, referral advice) (19)				
* Support with referring patients experiencing family, domestic or sexual violence (including child sexual abuse) to relevant support services (3)				
* Referred patients directly to the FDSV support workers (7)				
Advice about planning & implementing better policies & practices in relation to family, domestic or sexual violence (including child sexual abuse) (8)				
Support to develop clear referral processes for clients impacted by family, domestic or sexual violence (including child sexual abuse) (1)				
Building better working relationships with local FDSV support services (20)				
* Receiving feedback about the outcomes for patients you've referred to the FDSV support workers (21)				
Other – *Please specify*: (9)				

Q7.2 How would you rate your local FDSV support worker(s) in relation to ... ?

	Terrible 0	1	2	**OK/ It varied** 3	4	5	**Excellent** 6	7	8	9	Don't know 10
The quality of the support you've received ()											
The timeliness of the support you've received ()											

Q7.3 How much do you agree with the following statements about your local FDSV support worker(s)?

	Not at all 0	1	2	**Somewhat** 3	4	5	**Very much so** 6	7	8	9	Don't know 10
I feel comfortable referring my patients to them ()											
I feel comfortable approaching them for advice or support ()											

They have supported me to make appropriate referrals for patients disclosing experience of FDSV ()
I am confident in their ability to make appropriate referrals for my patients ()
They keep me informed about outcomes of referrals so I can continue to provide the best care for my patients ()
They understand the challenges health professionals face when responding to FDSV ()
They have helped our practice/service recognise and respond to FDSV ()
They have helped with managing the vicarious trauma associated with this work ()

Q8.1 **Thinking about the FDSV Initiative as a whole (ie: the resources, training, quality improvement and capacity building activities, as well as the local FDSV support workers) ....** To what extent do you think the FDSV Initiative has helped with improving your capacity in relation to each of the following?

	Not at all					Somewhat				Very much so	Don't know
	0	1	2	3	4	5	6	7	8	9	10
Identifying and/or supporting patients experiencing family or domestic violence ()											
Identifying and/or supporting patients who experienced sexual violence as an adult ()											
Identifying and/or supporting adult patients who experienced child sexual abuse ()											
Identifying and/or supporting children experiencing child sexual abuse ()											
Working safely & effectively with patients using violence & abuse ()											
Empowering your patients so they can choose the support services and legal options that they desire ()											

Display this question: If Q8.1 [Identifying and/or supporting patients experiencing family or domestic violence] >= 5

Q8.2 **You indicated an improvement in your capacity in relation to identifying and/or supporting patients experiencing family or domestic violence (FDV)** To what extent do you think your capacity has improved in relation to the following?

	Not at all					Somewhat				Very much so	Don't know
	0	1	2	3	4	5	6	7	8	9	10
Your understanding of the nature, drivers and impact of FDV ()											
Your ability to recognise the signs of FDV ()											
Your awareness of the barriers to disclosing and/or leaving FDV situations ()											
Knowing what to say and ask when patients disclose FDV or you suspect they have experienced it ()											
Your skills and knowledge of FDV risk assessment & management ()											
Your confidence discussing FDV with your patients ()											
Knowing how to appropriately record FDV in your patient management system ()											
Your awareness of local services that can support people experiencing FDV ()											
Your relationship with local FDV support services ()											
Having clear referral pathways between your practice/service and local FDV support services ()											
Your ability to support patients from diverse backgrounds experiencing FDV ()											

Display this question: If Q8.1 [Identifying and/or supporting patients who experienced sexual violence as an adult] >= 5

Q8.3 **You indicated an improvement in your capacity in relation to identifying and/or supporting patients experienced sexual violence as an adult (SVA)** To what extent do you think your capacity has improved in relation to the following?

	Not at all 0	1	2	3	4	5	6	7	8	9	Somewhat / Very much so 10	Don't know
Your understanding of the nature, drivers and impact of SVA ()												
Your ability to recognise the signs of SVA ()												
Your awareness of the barriers to disclosing SVA ()												
Knowing what to say and ask when patients disclose SVA or you suspect they have experienced it ()												
Your confidence discussing SVA with your patients ()												
Knowing how to appropriately record SVA in your patient management system ()												
Your awareness of issues pertaining to evidence preservation in cases of recent sexual violence ()												
Your awareness of local services that can support people having experienced SVA ()												
Your relationship with local SVA support services ()												
Having clear referral pathways between your practice/service and local SVA support services ()												
Your ability to support patients from diverse backgrounds experiencing SVA ()												

Display this question: If Q8.1 [Identifying and/or supporting adult patients who experienced child sexual abuse] >= 5 Or Q8.1 [Identifying and/or supporting children experiencing child sexual abuse] >= 5

Q8.4 **You indicated an improvement in your capacity in relation to identifying and/or supporting patients having experienced child sexual abuse (CSA)** To what extent do you think your capacity has improved in relation to the following?

	Not at all 0	1	2	3	4	5	6	7	8	9	Somewhat / Very much so 10	Don't know
Your understanding of the nature, drivers and impact of CSA ()												
Your ability to recognise the signs of CSA ()												
Your awareness of the barriers to disclosing CSA ()												
Knowing what to say and ask when patients disclose CSA or you suspect they have experienced it ()												
Your confidence discussing CSA with your patients ()												
Knowing how to appropriately record CSA in your patient management system ()												
Your awareness of local services that can support people having experienced CSA ()												
Your relationship with local CSA support services ()												
Having clear referral pathways between your practice/service and local CSA support services ()												
Your ability to support patients from diverse backgrounds experiencing CSA ()												

Display this question: If Q8.1 [Working safely & effectively with patients using violence & abuse] >= 5

Q8.5 **You indicated an improvement in your capacity in relation to working with patients using violence and abuse (PUVA)** To what extent do you think your capacity has improved in relation to the following?

	Not at all 0	1	2	3	**Somewhat** 4	5	**Very much so** 6	7	8	Don't know 9	10
Your understanding of the different types of violence & abuse ()											
Your ability to recognise someone who might be using violence and abuse ()											
Your awareness of the barriers to disclosing using violence and abuse ()											
Knowing what to say and ask when patients disclose using violence and abuse ()											
Your confidence discussing using violence and abuse with your patients ()											
Knowing how to appropriately record PUVA in your patient management system ()											
Your awareness of local services that can support PUVA ()											
Your relationship with local support services for PUVA ()											
Having clear referral pathways between your practice/service and local support services for PUVA ()											
Your ability to support PUVA from diverse backgrounds ()											
Ensuring your own and your colleagues safety when working with PUVA ()											

Q8.6 To what extent do you think the following FDSV Initiative components have contributed to improving your capacity to recognise and respond to FDSV? *Please select 1 rating for each component.* *Only engaged with components appeared.*

	Not at all (0)	**Maybe a little** (1)	**Minor contribution** (2)	**Moderate contribution** (3)	**Major contribution** (4)
The **FDSV-related training** you've attended (16)					
The **FDSV-related resources** you've accessed (17)					
The **FDSV-related quality improvement or capacity building activities** you've participated in (18)					
Support you've received from your local PHN staff and/or FDSV support workers (you may know them as a Local Link, Linker, Connector or FV worker) (3)					
Other factors – *Please specify*: (9)					

Q8.7 Is there any particular activity or resource that has had the biggest impact on your capacity to recognise and respond to FDSV? _____

Q8.8 To what extent do you think the FDSV Initiative has improved the ease with which the following patients can access relevant support services?

	Not at all 0 1 2	Somewhat 3 4 5 6 7	Very much so 8 9 10	Don't know
Patients experiencing family or domestic violence ()				
Patients who experienced sexual violence as an adult ()				
Adult patients who experienced child sexual abuse ()				
Minors experiencing child sexual abuse ()				
Patients using violence & abuse ()				

Display this question: If Q1.9 = Western Victoria PHN

Q49 **The following questions ask about your initiation of contact with local FDSV services, such as The Orange Door and Safe Steps.** Since completing the Family Violence A-LIVES training and support program, how often have you initiated the following: ... ?

	Never (0)	**Once or twice** (1)	**3-5 times** (2)	**6+ times** (3)
Sought **GENERAL advice** from local FDSV services (16)				
Sought **PATIENT-specific advice** (eg: case consultations) from local FDSV services (17)				
Made a **COLD referral** to local FDSV services *(giving a patient information about the service, so they can refer themselves if they choose)* (18)				
Made a **WARM referral** to local FDSV services *(giving a patient information about the service and, with their consent, contacting the service with or for the patient)* (3)				
Made a **WRITTEN referral** to local FDSV services *(by letter, email, fax, referral form, secure messaging, etc)* (8)				

Q50 Please share the names of the local FDSV services you've been engaging with for advice/referrals _____

Q51 How well have the services you've referred patients to kept you informed about the outcomes of those referrals so you can continue to provide the best care for your patients?

Not at all 0 10 20	Somewhat 30 40 50 60	Very much so 70 80 90 100

Q8.9 Do you have any suggestions for how the FDSV initiative could be improved or any other comments about additional supports needed? _____

Q9.1 **Finally, a few questions to help us group your answers.** Which age group do you fit into?

- Less than 20 years (1)
- 20s (2)
- 30s (3)
- 40s (4)
- 50s (5)
- 60+ years (6)
- Prefer not to say (7)

Q9.2 Which gender do you identify with?

Female (1)
Male (2)
Non-binary/ Other (3)
Prefer not to say (4)

Q9.3 Which best describes the area where you work?

Metropolitan (capital city areas) (1)
Regional (non-capital cities and surrounding areas) (2)
Rural (country towns and surrounding areas) (3)
Remote (places relatively far from a town and/or with minimal access to services) (4)

Q9.4 Do you identify as Aboriginal and/or Torres Strait Islander?

Yes (1)
No (2)
Prefer not to say (3)

Q9.5 Do you speak any languages other than English at home?

No, only English (1)
Yes - *please specify:* (2) _____
Prefer not to say (3)

Q9.6 Please indicate the name of your practice/service. *This information will be used to help us link the overall survey data with monitoring information being collected about the support provided to each practice/service through the Pilot.* ***Your responses will still be kept confidential and you or your practice/service will not be identified in our analyses or reporting.*** _____

Q10.1 Are there any other comments you'd like to make about the FDSV Intiative? This is the final question. _____

Appendix 5 — Semi-structured interview schedules

PHN staff/System Integrators

Overall
1. How did you find the experience of working in this system integration role? Did it operate as you expected?
2. Is there anything you think went particularly well? Anything you found particularly challenging?
Training - Implementation reflections:
3. What worked well, why? What worked less well, why? (e.g., recruitment/engagement, acceptability of the training content, acceptability of the training style)
4. Were there barriers/enablers to implementation? (e.g., COVID vaccine, GP willingness to engage, challenges with online training)
5. Do you feel the training has impacted local FDSV outcomes/primary care's ability to recognise, respond refer FDSV? If so, how? Why do you say this (what is the evidence)?
6. Any suggestions about how the training could be improved in the future?
System integration role - Implementation reflections:
7. What was the level of engagement with the GP practice staff and your role? What was the level of engagement with specialist FDSV services?
8. What other system integration activities or combination of activities were implemented in your location? (e.g., networking meetings, CoPs, advocacy, development of training/courses)
9. What worked well, why? What worked less well, why? (e.g., awareness of the role, engagement, acceptability of the model, limitations in scope of the role, referral pathways, QI processes, CoPs)
10. Were there barriers/enablers to implementation? (e.g., COVID vaccine, GP willingness to engage, capacity of FDSV services, limited timeframe)
11. Do you feel the system integration role and activities has impacted local FDSV outcomes/primary care's ability to recognise, respond refer DFV? If so, how? Why do you say this (what is the evidence)?
12. Do you feel that the approach has had an impact on the capacity of general practice staff to support priority populations such as Aboriginal and Torres Strait Islander, CALD, refugee/migrant women, people with a disability, LGBTI? How could this be improved?
13. Any other suggestions about how the system integration role could be improved in the future? (e.g., what modifications could be made to enhance the support provided by this role?)
Outcomes
14. Are there any other outcomes that have been achieved to date? (expected or unexpected). E.g.: - Increased GP referrals to local specialist FDSV services - Improved understanding among GP practices of the role of specialist FDSV services in supporting people who experience FDSV, and an increased trust in their ability to do so? - Improved understanding among FDSV services of the role of primary care in supporting people who experience FDSV - Improved capacity of GP practices to support priority populations such as Aboriginal and Torres Strait Islander, CALD, refugee/migrant women, people with a disability, LGBTI
15. Are there any other expected outcomes that haven't yet been realised?

Administrative staff

Training	
1.	How did you find the FDSV training you recently participated in? Anything you thought worked well? Anything that worked less well?
2.	Any suggestions for improvements?
3.	Has the training had any impact on you and or your practice? What have been these changes? (e.g. confidence, knowledge, the support provide to people experiencing FDSV, knowledge of local FDSV services, etc)
4.	How did you find the FDSV training you recently participated in? Anything you thought worked well? Anything that worked less well?
5.	Any suggestions for improvements?
System integration role	
6.	Have you engaged with the system integration role (e.g. local linker), and if yes, in what ways? How has your experience with the system integration role been? What has worked well? Any challenges?
7.	Could the function of the system integration role be improved? If so, how?
8.	Has this role had any impact on you and or your practice? What have been these changes? (e.g. confidence, knowledge, the support provide to people experiencing FDSV, knowledge of local FDSV services, etc)
Outcomes	
9.	Overall, since participating in the training and engaging with the system integration role, how would you rate the influence on the following, using a scale of 1 to 5 where 1 is not at all, and 5 is very high: - Your understanding of the role of FDSV specialist services - Your skills and confidence in recognising FDSV
10.	Can you please describe how the training and the system integration role influencing these changes? Was there anything in particular that you found most valuable? Do you feel one contributed to this change more than the other?
11.	Do you feel that the services you refer victim-survivors to routinely report back to you about the outcome of your referrals? If not, why?
12.	Do you have any other thoughts on how the model could be improved?

Health practitioners

Background
1. How long have you been practicing as a health practitioner and how long have you been at this practice?
2. How many health practitioners and admin staff are in the practice?
3. Thinking of the last 4 weeks, are you able to provide a rough estimate of how often you encounter patients experiencing FDSV. (Prompt: Would you say it is: Never/almost never; 1-4 per month; 5-10 per month; >10 per month)
4. Overall, how confident do you feel in identifying and supporting patients who have experienced FDSV?
5. What type of support do you generally offer to victim survivors?
Training
6. How did you find the FDSV training you recently participated in? Anything you thought worked well? Anything that worked less well?
7. Any suggestions for improvements?
8. Has the training had any impact on you and or your practice? What have been these changes? (e.g. confidence, knowledge, the support provided to people experiencing DFV, knowledge of local FDSV services, etc)
System integration role
9. Have you engaged with the system integration role (e.g. local linker), and if yes, in what ways? How has your experience with the system integration role been? What has worked well? Any challenges?
10. Could the function of the system integration role be improved? If so, how?
11. Has this role had any impact on you and or your practice? What have been these changes? (e.g. confidence, knowledge, the support provided to people experiencing FDSV, knowledge of local DFV services, etc)
Outcomes
12. Overall, since participating in the training and engaging with the system integration role, how would you rate its influence on the following, using a scale of 1 to 5 where 1 is not at all, and 5 is very high: - Your skills and confidence in recognising FDSV - The number and type of referrals you provide to DFV specialist services (e.g. more referrals, referring to different services) - Your understanding of the role of FDSV specialist services
13. Can you please describe how the training and the system integration role influenced these changes? Was there anything in particular that you found valuable? Do you feel one contributed to this change more than the other?
14. Do you feel that the services you refer victim-survivors to routinely report back to you about the outcome of your referrals? If not, why?
Key learnings
15. Do you have any other thoughts on how the model could be improved?

Appendix 6 — Number of training sessions and attendees by PHN, July 2022 – April 2025[19]

PHN	Training	N sessions	N attendees*
ACTPHN	A Trauma-informed Primary Health Care Response to DFV: Recognise, Respond, and Refer	5	31
(Recorded since March 2025)	**Total**	**5**	**31**
BSPHN	An Integrated Health Response to Family, Domestic and Sexual Violence and Child Sexual Abuse	1	5
(Recorded since July 2022)	Coercive Control	15	98
---	DFV Next Steps (follow on from the Introduction to DFV training)	1	2
---	Diverse Communities	9	21
---	Diverse Communities: CALD	5	5
---	Diverse Communities: First Nations	2	2
---	Diverse Communities: LGBTQIA+	2	1
---	Effects of DFV on Children and Young People	8	39
---	Information Sharing	8	55
---	Information Sharing and Documentation	5	25
---	Information Sharing and Legislation	6	33
---	Management of Non-Fatal Strangulation	4	8
---	Practical Case Study Review	1	9
---	RACGP Training - Extension (SV)	2	12
---	RACGP Training - Foundational (SV)	5	51
---	Recognise, Respond, Refer	36	180
---	Recognise Respond Refer: An Integrated Health Care Response to DFV	17	57
---	Recognise Respond Refer: Foundational Training	25	149

19 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	Training	N sessions	N attendees*
---	Recognise Respond Refer: Spotlight on Coercive Control	1	2
---	Sexual Violence (Extension session)	1	3
---	Sexual Violence (Foundational session)	2	16
---	Working with PUV and identifying risk	1	1
---	Other	4	23
---	**Total**	**161**	**797**
CESPHN	Responding to DFV in Primary Care	109	457
(Recorded since January 2024)	Sexual Violence: A whole practice approach	11	18
---	Strengthening Clinical Practices to Safeguard Adults Vulnerable to Abuse in Their Family, Home and Community	23	23
---	**Total**	**144**	**498**
HNECCPHN	A Trauma-informed Primary Health Care Response to DFV: Recognise, Respond, and Refer	1	10
(Recorded since October 2022)	Child Sexual Abuse Training	2	17
---	Child Sexual Abuse: A whole practice approach	1	9
---	DFV Combined Level 1 and 2	3	59
---	DFV Combined Training	38	101
---	DFV Education and Networking Dinner- "a whole of community approach to ending DFSV"	6	11
---	DFV in the context of culture & identity: Aboriginal and Torres Strait Islander Peoples	1	20
---	DFV Level 1	35	358
---	DFV Level 2	16	142
---	First Nations Mental Health - Presentation	1	20
---	Recognise Respond Refer: An Integrated Health Care Response to DFV	2	7
---	Registrar seminar (RACGP)	2	92
---	Responding to DFV in Primary Care	1	12

PHN	Training	N sessions	N attendees*
---	Responding to First Nations clients	1	50
---	Sexual Violence / Child Sexual Abuse Combined training	1	2
---	Sexual Violence Training	8	52
---	Sexual Violence: A whole practice approach	1	14
---	Other	7	65
---	**Total**	**127**	**1,041**
NBMPHN (Recorded since January 2023)	Certificate of injury form	1	12
	CSA training	22	50
---	DFSV Action Plan	8	20
---	DFV housing support form	1	7
---	GP Action Plan	5	11
---	Introduction to DFV training	18	54
---	Introduction to DFV training & RRR	1	6
---	MRG online (GP had never done an MRG before (or one online)	1	11
---	Other	1	9
---	Recognise, Respond, Refer	32	224
---	Secure messaging	1	1
---	Sexual Violence Training	21	47
---	**Total**	**156****	**452**
NTPHN (Recorded since July 2024)	Blueknot Safety	1	1
	Child, Youth and Family Intervention	2	2
---	Complex Trauma Foundational	1	1
---	DFSV Fundamentals	9	120
---	DV Alert	1	2
---	Forensic Nursing	1	1
---	Managing Wellbeing and Recognising Violence	1	1
---	Mandatory Reporting	2	6
---	Other	7	20
---	Stabilisation Training	1	1
---	Trauma Focused ACT	2	3
---	Trauma-informed approaches to DFSV Screening	2	8
---	**Total**	**30**	**166**

PHN	Training	N sessions	N attendees*
NWMPHN	Pathways to Safety Readiness (Primary Care)	42	171
(Recorded since January 2024)	Pathways to Safety program	24	49
---	**Total**	**66**	**220**
WAPHA	Understanding and responding to Intimate Partner Violence	8	63
(Recorded since November 2024)	**Total**	**8**	**63**
WVPHN	FDSV A-LIVES - Clinical Session	5	39
(Recorded since June 2024)	FDSV A-LIVES - Non-Clinical Session	5	18
---	FDSV A-LIVES - Combined Clinical and Non-Clinical Session	11	83
---	FDV A-LIVES - FDV Clinical Group Session	33	260
---	FDV A-LIVES - FDV Non-Clinical Group Session	11	64
---	Wanga Laka Family Violence Workshop	2	19
---	**Total**	**67**	**483**
Total	**---**	**764**	**3,751**

* Some individuals may have attended multiple training sessions

** There were 44 training sessions recorded by NBMPHN which did not contain any information such as training name, number of attendees or practice type.

Appendix 7 — Number and type of resources provided by PHN

PHN	Resource name	Number of resources
ACTPHN	CRCC Link Worker Business Cards	137
---	DFV Link Worker Business Cards	65
---	FDSV Link Worker Referral Form	147
---	Information and flowchart on referring to the DFV link worker	77
---	Information sheet on referring to CRCC Link Workers	108
---	Overview of FDSV program	14
---	Power and Control Wheel	3
---	Responding to Child Sexual Abuse: Referral Pathway Flowchart	110
---	Responding to DFV: Referral Pathway Flowchart	6
---	Responding to Sexual Violence: Referral Pathway Flowchart	111
---	Role Play Video (GP and DFV victim-survivor)	19
---	**Total**	**797**
BSPHN	Adolescent to parent violence book	25
---	CFW Booklet	22
---	CFW Health In My Language poster	1
---	CFW Local Link Business Card	17
---	CFW Local Link Referral Form	87
---	CFW Local Link Training Brochure	13
---	CFW Local Link Flyer	114
---	CFW Working with CALD Communities booklet	3
---	Coercive Control posters	9
---	CRASF CYP handout	7
---	DFSV/Child Sexual Abuse Posters	4
---	DFV poster (covert) for women's bathrooms	19
---	DFV Risk Indicators and Safety Strategies Guide	6
---	DFV Training Flyer	27
---	Do No Harm booklet	90

PHN	Resource name	Number of resources
---	DV Cycle of abuse	1
---	DVO Quick Help Guides	21
---	Elder Abuse resources	3
---	Equality Wheel poster	2
---	Fact Sheet - DFV after Natural Disasters	14
---	FDSV Link Worker Flyer and Referral Form	10
---	Foundation Training Booklet	1
---	Hand sanitisers (covert resource to support engagement)	3
---	He doesn't hit you but he ..' poster	5
---	Health In My Language Flyer	2
---	Healthy Relationships Book	39
---	Impacts on Children CRASF Resource	1
---	Information Sharing Guidelines	1
---	It's Not Just Physical resource	1
---	Local Link Business Card	24
---	Local Link Flyer	94
---	Local Link Flyer and Training brochure	98
---	Local Link Program Resources	27
---	Local Link Referral Form	73
---	Men's Behaviour Change poster	2
---	Men's Wellbeing Guides	55
---	Myth buster cards	91
---	Myth buster posters	3
---	New Beginnings Support Group	1
---	Post training resource booklet	5
---	Power and Control Wheel	22
---	Program Flyer and Referral Form	20
---	Program Training Brochure	12
---	Quick phone guide for women and families - Logan	256
---	Quick phone guide for women and families - Redlands	96
---	RACGP training brochure	13

PHN	Resource name	Number of resources
---	RACGP training resources	11
---	References and Resources	2
---	Sexual violence reporting options QLD Brochure	3
---	Strengthening GP responses to child sexual abuse in primary health care (NCACSA Practice tool)	7
---	Strengthening GP responses to sexual violence in primary health care (NCACSA Practice tool)	11
---	Strong Women Hard Yarns	4
---	Training Resource Booklet	10
---	Women's Wellbeing Guide	39
---	Working with CALD women resource	28
---	Working with victims and survivors of child sexual abuse and sexual violence (NCACSA video)	2
---	"Your Role" Card	5
---	"Your Role" Flyer	2
---	**Total**	**1,564**
CESPHN	Blueknot Foundation factsheet about trauma-informed care	11
---	CESPHN Map of Practice LHDs and Sexual Assault Services	11
---	Charmed and Dangerous	70
---	Cycle of Violence Image	6
---	DFSV Action Plan	7
---	DFSV/Child Sexual Abuse Posters	9
---	DFV Resources and Support Services Directory	51
---	Equity Wheel	18
---	GP considerations relating to sexual violence	11
---	Managing Non-Fatal Strangulation in Primary Care	66
---	Navigator business cards	9
---	NFS infograph	2
---	Power and Control Wheel	16

PHN	Resource name	Number of resources
---	RACGP White book	100
---	Responding to NFS, sexual choking and brain injury	2
---	Safety planning resources and links	1
---	Strangulation in IPV Fact Sheet	99
---	Subpoena Survival Guide	113
---	Victim Services info (incl Certificate of Injury form)	11
---	WDVCAS brochure	175
---	WDVCAS brochure (in other languages)	30
---	WDVCAS card	184
---	WDVCAS poster	6
---	**Total**	**1,008**
HNECCPHN	1800 Respect bookmark and card	3
---	A5 Flyer Be prepared Do the training	72
---	Business card	35
---	CCDVCAS brochures	82
---	Centrelink resources	1
---	Charmed and Dangerous	468
---	Coercive Control Waiting Room Poster	53
---	DFV Linker Business Card	373
---	DFV Resources	10
---	DFV Support Services Directory	11
---	DFV Start the Conversation Guide	97
---	DFV Training Flyer	36
---	DFSV Action Plan	16
---	DFSV Folder and Introduction letter	6
---	DFSV Linker Program brochure	81
---	DFSV Notepad	20
---	DFSV Pocket Guide	4
---	DSWB stickers	12
---	DV committee purple card	210
---	Elder Abuse Resources	1
---	FDSV Action Plan	5

PHN	Resource name	Number of resources
---	FDSV Worker Referral Form	2
---	Linker Business Card	45
---	Linker's Business Card and Introduction Letter	28
---	Managing Non-Fatal Strangulation in Primary Care	46
---	National Redress Scheme brochure	2
---	NWDVCAS brochure	280
---	NWDVCAS notepad	135
---	NWDVCAS pens	106
---	NWDVCAS postcard	35
---	NWDVCAS referral form	1
---	Power and Control Wheel	61
---	Safe and healthy pamphlet	3
---	Safer Options IPV (Intimate Partner Violence) posters and flier	10
---	Saro cards	82
---	Scan me cards	165
---	Scan/QR Code Card	50
---	Set of 3 Safe and Healthy posters	12
---	Sexual Assault Service Card	12
---	Signs of Strangulation Card	90
---	Spot the Signs Pamphlet	19
---	Start the Conversation A5 Card	20
---	Subpoena Survival Guide	2
---	WDVCAS brochures	33
---	WDVCAS cards	255
---	Women's Safety Hub Postcard	120
---	**Total**	**3,210**
NBMPHN	Charmed and Dangerous	2
---	DFSV Action Plan	41
---	DFV Linker Business Card	42
---	DFV Linker Flyer	42
---	Guide to the DFV GP Action Plan	7

PHN	Resource name	Number of resources
---	PHN DFV Linker website	40
---	Relationships Australia resource bag	42
---	WILLOW resource information	39
---	**Total**	**255**
NTPHN	MR Flowcharts	10
---	Training Handouts	104
---	**Total**	**114**
NWMPHN	5As Model	2
---	Adolescent FV in the home	1
---	FDSV posters	22
---	FDSV Follow-up resources	8
---	FDSV Resources in other languages	10
---	GP FV Info Pack	27
---	Indigenous FV resources	2
---	Management of the whole family	2
---	Orange Door Referral Form and Brochure	6
---	Practice readiness checklist	1
---	Practice-specific resources	1
---	Training pre-reading	19
---	Training session slides	11
---	Other	6
---	**Total**	**112**
WAPHA	RACGP White book	5
---	Strengthening GP responses to child sexual abuse in primary health care (National Centre Practice tool)	5
---	**Total**	**10**
WVPHN	BAIFVC MARAM Summary Guide and Brief Risk Assessment	7
---	Enhancing Safety	2
---	FDSV A-LIVES Overview	3
---	FDSV A-LIVES Resources Pack (includes ALL resources)	63
---	FDSV Additional Resources	3

PHN	Resource name	Number of resources
---	FDSV Follow up resources (including e-copy of all hard copy resources)	14
---	FDSV Program Resources	18
---	Local referral support services (not Orange Door)	13
---	Non-Fatal Strangulation resources	10
---	Policy and Procedure Template	7
---	QIA PDSA	6
---	RACGP White book	13
---	Safe Steps Information in other languages	1
---	Strangulation information	7
---	Wanga Laka Workshop resource booklet	1
---	**Total**	**168**
All PHNs	**---**	**7,238**