



# NEPEAN BLUE MOUNTAINS RECOGNISE, RESPOND & REFER **RRR** PILOT

Improving the primary care response to  
domestic and family violence within  
Blue Mountains, Hawkesbury, Lithgow and Penrith.

Report for Wentworth Healthcare Ltd - Provider of the  
Nepean Blue Mountains Primary Health Network

January 2021

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We acknowledge the traditional custodians of the lands on which we work and pay our respect to Aboriginal Elders, past and present. The Dharug, Gundungurra and Wiradjuri people are acknowledged as the traditional owners of the land in our region.



Report for Wentworth Healthcare

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## 1. BACKGROUND & CONTEXT

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Domestic and Family Violence (DFV) is a significant public health and societal issue that can have a lifelong impact on those who experience it and those that perpetuate it. In 2016, it was reported that Australian Police received a call every two minutes in relation to a DFV dispute<sup>1</sup>, and it was estimated that approximately 2.2 million adults had been victims of DFV<sup>2</sup>. Based on the 2012 Personal Safety Survey, violence against women and children cost Australian society \$22 billion in 2015-16, a figure that is likely an underestimation due to under-representation and lack of reporting<sup>3</sup>. With 52% of those costs borne by the victims and survivors themselves.

But the road to recovery is not straight. DFV is a complex issue involving multiple types of violence that go beyond the physical, including emotional and financial abuse and controlling behaviours. There is also a hidden aspect of DFV, where many of those experiencing it do not report it, or in some cases, do not recognise it as violence.

The term DFV is used in this report to include but is not limited to:

- Sexual violence
- Physical violence
- Psychological abuse
- Emotional abuse
- Spiritual violence
- Financial abuse
- Technology abuse
- Stalking

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<sup>1</sup> Claire Blumer, "Australian police deal with domestic violence every two minutes," *Australian Broadcasting Centre*, April, 21, 2016, <https://www.abc.net.au/news/2016-04-21/domestic-violence/7341716?nw=0>

<sup>2</sup> Australian Institute of Health and Welfare 2019. Family, domestic and sexual violence in Australia: continuing the national story 2019—In brief. Cat. no. FDV 4. Canberra: AIHW [https://www.aihw.gov.au/getmedia/b180312b-27de-4cd9-b43e-16109e52f3d4/aihw-fdv4-FDSV-in-Australia-2019\\_in-brief.pdf.aspx?inline=true](https://www.aihw.gov.au/getmedia/b180312b-27de-4cd9-b43e-16109e52f3d4/aihw-fdv4-FDSV-in-Australia-2019_in-brief.pdf.aspx?inline=true)

<sup>3</sup> KPMG, "The cost of violence against women and their children in Australia" May 2016, Retrieved from : [https://www.dss.gov.au/sites/default/files/documents/08\\_2016/the\\_cost\\_of\\_violence\\_against\\_women\\_and\\_their\\_children\\_in\\_australia\\_-\\_summary\\_report\\_may\\_2016.pdf](https://www.dss.gov.au/sites/default/files/documents/08_2016/the_cost_of_violence_against_women_and_their_children_in_australia_-_summary_report_may_2016.pdf)

While DFV does not discriminate, there are groups in society who are considered more vulnerable to experiencing DFV throughout their lifetimes. Women are significantly more likely to experience DFV, with 1 in 6 experiencing physical or sexual violence and 1 in 4 experiencing emotional abuse by a current or former partner<sup>4</sup>.

Other groups who are more at risk include:

- People living with a disability
- Indigenous Australians – 32 times as likely than non-Indigenous to be hospitalised for family violence<sup>5</sup>. Some research suggests that 90% of DFV experienced by Aboriginal and Torres Strait Islander women is not reported<sup>6</sup>.
- Lesbian Gay Bisexual Transgender Intersex Queer + (LGBTIQ+) - nearly twice as likely to experience sexual harassment at work
- Culturally and linguistically diverse (CALD) communities – this includes instances of forced marriage involving young females
- Rural and remote communities – 24 times as likely than metropolitan communities to be hospitalised for domestic violence; and
- Socioeconomically disadvantaged communities – 1.5 times as likely as those in less disadvantaged areas to experience partner violence.

The Nepean Blue Mountains region is made up of four local government areas: Blue Mountains, Hawkesbury, Lithgow and Penrith. The prevalence of DFV varies significantly across the region.

Penrith reported the highest rate of DFV related assaults, with 632.4 per 100,000, ranking 27<sup>th</sup> out of 128 LGAs in Australia. Lithgow ranked 39<sup>th</sup> (526.9), Hawkesbury 69<sup>th</sup> (351.8) and the Blue Mountains 98<sup>th</sup> (218.3)<sup>7</sup>.

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<sup>4</sup> IBID, 2019

<sup>5</sup> Australian Institute of Health and Welfare 2019. Family, domestic and sexual violence in Australia: continuing the national story 2019—In brief. Cat. no. FDV 4. Canberra: AIHW

<sup>6</sup> Special Taskforce on Domestic and Family Violence in Queensland, 2015, Not now, not ever: putting an end to domestic and family violence in Queensland. Retrieved from <https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/about/not-now-not-ever-report>

<sup>7</sup> Bureau of Crime Statistics and Research (BOCSAR), NSW Local Government Area excel crime tables. Retrieved from: [https://www.bocsar.nsw.gov.au/Pages/bocsar\\_crime\\_stats/bocsar\\_lgaexceltables.aspx](https://www.bocsar.nsw.gov.au/Pages/bocsar_crime_stats/bocsar_lgaexceltables.aspx)

## 1.1 The Recognise Respond Refer Pilot

The Recognise Respond Refer (RRR) program is an initiative developed by Brisbane South Primary Health Network (BSPHN) in collaboration with The Australian Centre for Social Innovation to improve outcomes for people experiencing DFV, and their families.

Following their 2018 needs assessment, BSPHN identified a gap in “integrated services to respond to domestic and family violence at a primary health care level”. The RRR program was developed in response to this, aiming to support and improve system responsiveness by placing primary health care into a broader system response to DFV in their local population.

The program was designed and modelled on the Identification and Referral to Improve Safety (IRIS) trial in the United Kingdom and the Women’s Evaluation of Abuse and Violence Care (WEAVE) trial in Victoria.

A central feature of the pilot, and those it is based on, is that it cements the role of health, particularly primary health care, as a critical component of what a successful multi-sectoral response to DFV would look like. IRIS and WEAVE demonstrated the positive impact of building the capacity of general practitioners and primary care more broadly<sup>8</sup>.

As identified in the report by the Special Taskforce on Domestic and Family Violence in Queensland<sup>9</sup>, GPs are often the first contact that women and children experiencing DFV have with the health and service system, and are likely seeing between one to two women per week who have experienced DFV. However only one-third of women disclose to their GP and only one in 10 women experiencing DFV are asked directly by their GP, with only 14% of referrals to DFV services being received on average from general practitioners<sup>10</sup>.

In its most simple form, the RRR program helps primary care recognise people who are experiencing DFV, be able to respond appropriately to the needs of that person, and then refer them to, and work collaboratively with, agencies that are in the best position to assist them. In developing the program, consideration was given to primary care workloads, insisting the program needs to “meet GPs where they are as opposed to getting them to do more.”<sup>11</sup>

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<sup>8</sup> The Australian Centre for Social Innovation (2019), Recognise, respond, refer: An integrated health response to domestic & family violence. Developing a model for an integrated response to DFV.

<sup>9</sup> Special Taskforce on Domestic and Family Violence in Queensland, 2015, Not now, not ever: putting an end to domestic and family violence in Queensland.

<sup>10</sup> Cameron, P. (2016). Expanding early interventions in family violence in Victoria. Melbourne: Domestic Violence Victoria. <http://dvvic.org.au/wordpress/wp-content/uploads/2017/02/Early-Intervention-Report-FINAL-8-DEC.pdf>

<sup>11</sup> The Australian Centre for Social Innovation (2019), p.16

With this in mind, while the following report highlights suggestions on how the program could work for primary health in the Nepean Blue Mountains area, it is important to note that this does not mean this is already occurring. Instead, the program aims to support these actions in a more coordinated and integrated way.

To offer this support to primary care, the pilot also includes a role known as the DFV Linker. The role has two key components; they will be the main point of referral for those accessing support for DFV through their GP, and they will be available to offer advice and guidance to primary care to enhance primary care's identification and response to DFV.

DFV is often considered a gendered issue. Women are statistically much more likely to be affected by DFV, and the availability of data and evidence surrounding DFV mostly pertains to women as victims and survivors. The RRR program, however, works with and is accessible to all individuals experiencing DFV.

The Commonwealth Government announced \$9.6 million between 2019-20 and 2022-23 to fund the continued delivery and expansion of the RRR program. The PHN's included were Brisbane South, Central and Eastern Sydney, Nepean Blue Mountains, North Western Melbourne, Hunter New England and Central Coast, and Western Victoria. The funding also includes the program evaluation across all of these six sites. The remainder of the funding was directed towards the National Training for Primary Health Care Workers program, including updating the Royal Australian College of General Practitioners' *White Book*, and delivering trauma informed training for the primary care sector<sup>12</sup>.

## 1.2 The project

Synergia was engaged to support the DFV Program Development Officer at the Nepean Blue Mountains Primary Health Network (NBMPHN) to design and support the implementation of the Recognise, Respond, Refer (RRR) pilot program in the Nepean Blue Mountains region.

As one of the five PHNs involved in the national expansion, the intent was to undertake this process through a co-design approach, working collaboratively with general practices, and government and non-government organisations and services who have an area of expertise within the DFV area to ensure the pilot was fit-for-purpose for the different regions across the Nepean Blue Mountains.

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<sup>12</sup> Australian Government, National plan to reduce violence against women and their children. Retrieved from: <https://plan4womenssafety.dss.gov.au/initiative/expansion-of-the-recognise-respond-and-refer-pilot-and-national-training-for-the-primary-care-workforce/>

### 1.3 The report

This report provides insight into the approach and outputs from the co-design process. It highlights the key challenges and barriers currently perceived to be affecting those experiencing DFV and reaching out for support.

The findings section of the report is separated out into the four key parts of the model; recognise, respond, refer and the DFV Linker. These subsections highlight the suggestions we heard from participants that should be considered throughout the implementation phase of this pilot to ensure it is fit-for-purpose and effective.

While these findings reflect input from across region, there is likely to be a need to modify aspects of the pilot to meet local needs. These will need to be addressed by the steering committee during the implementation phase. To support the implementation phase, we have concluded this report with a series of key questions that will help guide the NBMPHN and steering committee towards a successful and sustainable program.

## 2. THE CO-DESIGN PROCESS

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With a goal to bridge gaps across the DFV system, it was imperative that the process of designing and implementing the RRR pilot captured the perspectives of those who will be involved in its implementation.

Restrictions imposed by the COVID-19 pandemic meant that face-to-face engagement was not possible, so the co-design process was designed to ensure that appropriate and effective engagement and data collection could still be achieved. This was done using a combination of online software tools including Zoom [for managing online meetings], email [to facilitate communication], interactive documents [to obtain feedback from participants] and Miro [for collaborative work]. The use of these tools is detailed below in section 2.2.

### 2.1 Stakeholders

Working with the DFV Program Development Officer, we identified stakeholders across the four communities in the Nepean Blue Mountains Region covering a range of services, including primary health care providers, DFV agencies, broader community organisations and, where appropriate, lived experience.

38 stakeholders were identified and invited to be involved, of which 27 stakeholders engaged with the process.

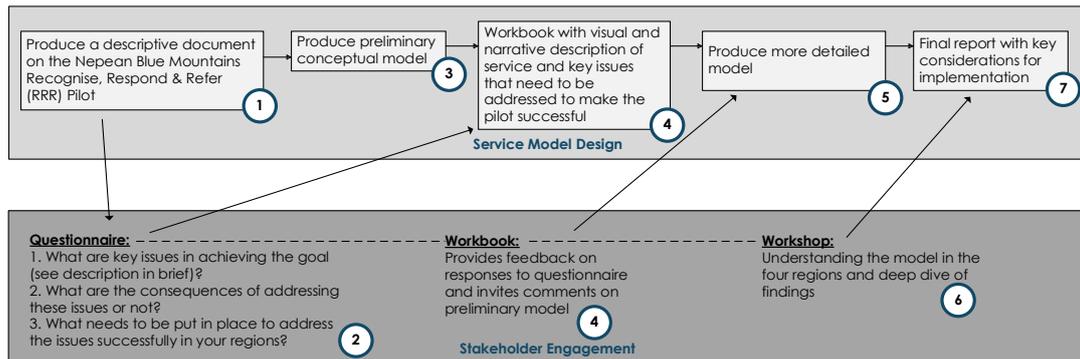
Those involved are listed below:

ACON	Lithgow Community Projects
Benevolent Society	Lived experience volunteers
Blue Mountains Women's Health and Resource Centre	Mt Druitt Family Violence Service
Department of Communities & Justice	Myhealth North Richmond
Dr Hanumayya Adusumilli	Nepean Community Neighbourhood Service
Dr Louise Karan	Nurreen Women's Housing
DV West	Penrith Women's Health Centre
Elizabeth Evatt Community Legal Centre	Peppercorn Family Services
Elyse O'Shannessy, Practice Manager	The Haven
Gateway Family Services	Thrive Services
Greater West Aboriginal Health Service	Wesley Mission
Hawkesbury City Council	Women's Cottage
Housing Plus	Women's Domestic Violence Court Advocacy Services
Integrated Violence Prevention & Response Service	

## 2.2 Overview of Approach

The approach followed for this project included a mix of individual tasks and online workshops. The mix of activities used in this project supplemented the online workshop and led to a more focused and informed workshop agenda.

The overall steps in our approach are shown in the following graphic:



This process utilised a modified Delphi approach, in which ‘participants were asked to respond to key questions relating to the RRR pilot. The results from this first round were then compiled into a workbook and sent out for further review. The results from the second round informed the structure of the workshop which was designed to tease out, in more detail, the responses obtained in the initial questionnaire and subsequent workbook.

The Delphi method was originally designed as a group technique used to obtain the “most reliable consensus of opinion of a group of experts”<sup>13</sup> relying on a “series of intensive questionnaires”. Less concerned with overall consensus, the current focus of the Delphi method is to use structured communications to elicit input from a wide range of people, tackling complex problems.

It is characterised as an iterative, anonymous and controlled method. Usually, the first questionnaire generates a broad range of responses. In this stage, we wanted to allow for all innovative responses to be included. In round two, a workbook was designed to focus and prioritise the initial set of responses.

Important to the current COVID-19 context, the Delphi method is a very useful tool for obtaining input from people who are not able to meet face-to-face.

Below, we briefly outline the process we followed:

<sup>13</sup> Landeta, J. (2006) *Current validity of the Delphi method in social sciences*, *Technological forecasting and Social Change*, 73, 467-482

## 2.2.1 Background of the RRR Pilot

As a foundation for this work, we worked with key staff from the NBMPHN to develop an understanding of the pilot. Using this information, we wrote a background document to provide participants with a concise and easy-to-understand description of the RRR pilot. This was to ensure that all participants had the knowledge they needed to provide their insights into the design and implementation of the RRR pilot in their local context. As noted above, NBMPHN staff developed a list of stakeholders who would receive the background document and be invited to participate in the process.

The background document is titled "Improving the health system response to domestic and family violence within the Nepean Blue Mountains region." It is a multi-page report with the following content:

- Logos:** SYNERGIA, phn (Primary Health Network), and Wentworth Healthcare.
- Introduction:** Domestic and Family Violence (DFV) is recognised as a significant issue at national, state and local levels. It is widely acknowledged that any potential solution to DFV is exceedingly complex and requires multi-disciplinary collaboration between government and non-government agencies.
- Wentworth Healthcare:** Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Health Network (NBMPHN), has been funded to implement a pilot program designed to improve the primary healthcare response for those experiencing, or at risk of, domestic and family violence (DFV), through the integration and coordination of the DFV system and primary care sector.
- RRR Model:** The pilot is based on Brisbane South PHN's "RRR: recognise, respond and refer" model which was designed and commissioned based on trials from the UK and Victoria where both demonstrated the benefits of building capacity of primary care providers responding to DFV. The research also highlighted the important role played by primary care, who are often the first point of contact for those experiencing DFV within the health system.
- Collaboration:** NBMPHN intends to work collaboratively with general practices and DFV providers from Blue Mountains, Hawkesbury, Illawong and Penrith regions to implement the RRR model and co-design a localised approach.
- Recognise, Respond, Refer program:**
  - The RRR program aims to support primary health care professionals to improve overall system responsiveness to people experiencing DFV and improve outcomes for these individuals and their families. It seeks to achieve this by implementing a system integration model that positions the primary health care network as part of the broader system response to DFV.
  - The pilot involves building capacity within general practice in relation to DFV, providing them with detailed information about their local DFV services and referral pathways; and providing support with access to a DFV Linker who will act as the "conduit" between the practice team, DFV services and the patient.
  - The Role of Primary Health Care:** Treatment for the physical and mental health effects of violence is the obvious intersection between DFV and the healthcare system.
- However, for many of those affected by DFV, contact with a primary healthcare professional can be their only link to a community-based service, with an average of seven to eight visits occurring prior to disclosure. Because of the level of interaction people experiencing DFV have with the primary healthcare sector, and the interdisciplinary nature of the issue, potential solutions to this epidemic will require innovative responses from all sectors. The program recognises that primary healthcare is an already busy and under-resourced environment and so it aims to meet GPs where they are and support them, rather than create more work for them. It also acknowledges that DFV services are seeing an increase in client numbers in an already "stretched" sector so by working together, we aim to determine the enablers, challenges and gaps to improve the patient outcomes for those presenting with DFV within general practice.**
- Guided by five principles:**
  - Based on what was learned from the Brisbane South PHN RRR pilot, phn data and lived experience evidence, to help govern and shape and actions of the model.
  - Principles:**
    - 1. Promoting gender equity and challenging violence supporting attitudes.
    - 2. Understanding complexity & diversity of DFV.
    - 3. Acknowledging different experiences, needs and outcomes.
    - 4. Being aware of our own professional limitations and reflect on to ensure appropriate care.
    - 5. First priority of any response when risk is identified, leading to appropriate responses and outcomes.
    - 6. Meeting immediate safety for women & children.
- Interconnected:** It has been identified, all of which are dependent on one and other to ensure maximum positive impact.
  - Recognise, Respond, Refer Training:** Increasing the capability of primary care staff to understand and respond to DFV.
  - Primary Care Role:** Bring primary care into an integrated health system response to create a climate for disclosure, and stay involved post disclosure and release.
  - System Influence:** Bring influential system stakeholders together to address structural and relational barriers currently preventing problems being recognised and alternative solutions being adopted and scaled.
  - Evaluation, Design and Research:** Building measurement, evaluation, co-design and prototyping approaches into the model to ensure that it keeps evolving and improving the lives of people affected by DFV.

### 2.2.2 Initial questionnaire

For the first phase of data collection, a questionnaire was developed to obtain high-level feedback from the participants about the pilot.

The questionnaire had three main sections; key stakeholders, understanding collaboration, and the DFV linker, which is a central part of the pilot design.

Nine questions were asked across these sections, with a focus on barriers, enablers, incentives and challenges.

The questionnaire was sent to all stakeholders, totalling 50 participants representing 38 different organisations.

26 questionnaire responses were received and we analysed these using cognitive mapping<sup>14</sup> and general inductive thematic analysis<sup>15</sup>.

### 2.2.3 The Workbook

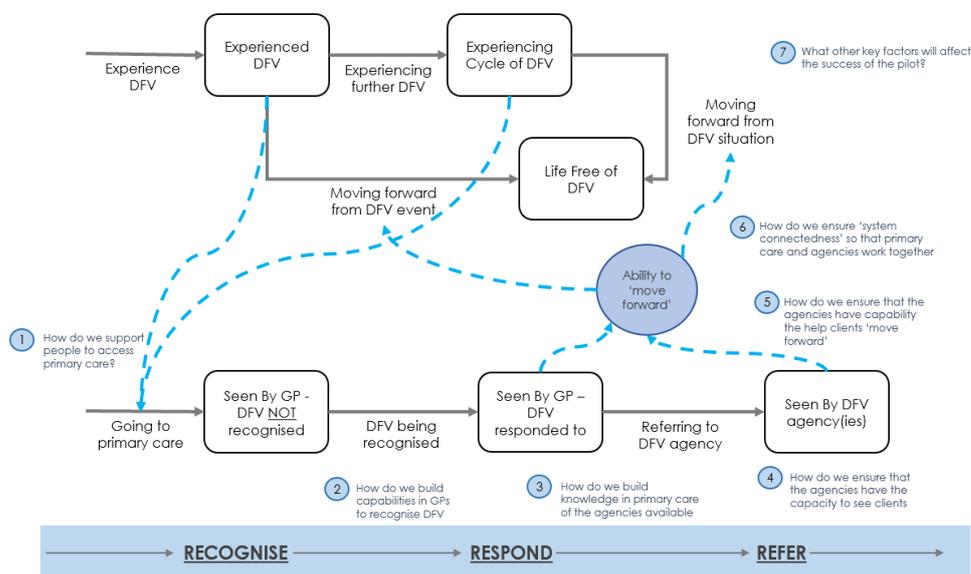
The second phase of data collection used a workbook to obtain further detail about the key themes that emerged from the questionnaire.

Using material describing the RRR model and the data from the questionnaire, we developed a high-level concept model, pictured below, that highlighted how individuals experiencing DFV would likely flow through the system if it was working well and what would be required for that to occur.

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<sup>14</sup> Eden, C., & Ackermann, F. (2004). Cognitive mapping expert views for policy analysis in the public sector. *European Journal of Operational Research*, 152(3), 615-630. doi:10.1016/s0377-2217(03)00061-4

<sup>15</sup> Thomas, D. (2009). A general inductive approach for analysing qualitative data. *American Journal of Evaluation*, vol 27(2)



**Figure 1: Concept model - a patient's journey**

The workbook summarised the key findings from the questionnaire and presented the journey model to participants. It asked specific questions about what would be required for it to work effectively, and showed how the RRR model could assist clients flow through the system. The questions asked in the workbook were informed by the structure of the concept model and the key themes that emerged from the questionnaire.

As an example, a theme that came through the questionnaire was that some GPs lack knowledge surrounding DFV services and how to access them. The workbook aimed to delve into this further by asking participants to think about how knowledge could be improved and maintained and what barriers would need to be addressed to do this.

The workbook was sent to 28 participants. This included those who had responded to the questionnaire and those who had indicated they would continue being involved in the project.

16 workbook responses were collated and again analysed for themes. This time however, there was a specific focus on aligning the themes and emerging ideas with the RRR model.

Some of the information gathered throughout the process highlighted key system or infrastructure barriers and, therefore, were set aside as they are issues outside of the scope of the RRR pilot.

### 2.2.4 The Workshop

While the previous steps enabled us to collect a lot of information, the ability for people to hear and learn from the ideas of others was not possible in this process. The prime purpose of the workshop was, therefore, to bring participants together, using the same structure they had been presented within the concept model, to share their ideas about how each of the three phases of recognise, respond and refer could be implemented successfully. Much of what was discussed in the workshop had been previously mentioned in the workbook. However, those ideas were able to be shared and discussed, creating a greater sense of shared commitment.

Given the constraints we were working under during the COVID-19 pandemic, having the ability to work with people in a more interactive way was crucial to building further engagement and commitment to the pilot. As a result, we designed an entirely remote workshop, underpinned by previous research into successful ways of delivering online workshops<sup>16</sup>.

Using a mixture of Zoom and Miro, our aim was to have a workshop that would be highly interactive, creative and involve participants in the thinking rather than simply an online discussion of ideas. 17 people participated in the workshop representing DFV agencies primary care and lived experience. Due to COVID-19, we felt most would be familiar with Zoom which was used as the central meeting space. To ensure attendees were comfortable with the relatively new technology, we introduced them to the software (Miro, a digital whiteboard tool) while on zoom and designed an icebreaker introduction activity in Miro, using the tools that would be required for the remainder of the workshop.

The workshop re-introduced the themes that emerged from the questionnaire and workbook, aligned to the RRR pilot. Using Miro, we encouraged participants to delve deeper into the high level ideas and think about what needs to be done to ensure those experiencing DFV can get the support they need and how that might be achieved. The journey model shown earlier formed the framework for the workshop structure. Alongside the key themes this was used to identify the main touch points of the journey (recognising DFV, responding to DFV and referring someone experiencing DFV), what needs to be done to ensure those experiencing DFV can get the support they need, and how that might be achieved.

Feedback from participants indicates that, for some, the use of the Miro software was not successful, with the technology getting in the way of discussion. This will need to be reviewed in future workshop designs, given that restrictions to face-to-face meetings are likely to continue for some time.

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<sup>16</sup> Brooke Wilkerson et al., (2020), Reflections on adapting group model building scripts into online workshops. *System Dynamics Review*, doi: 10.1002/sdr.1662

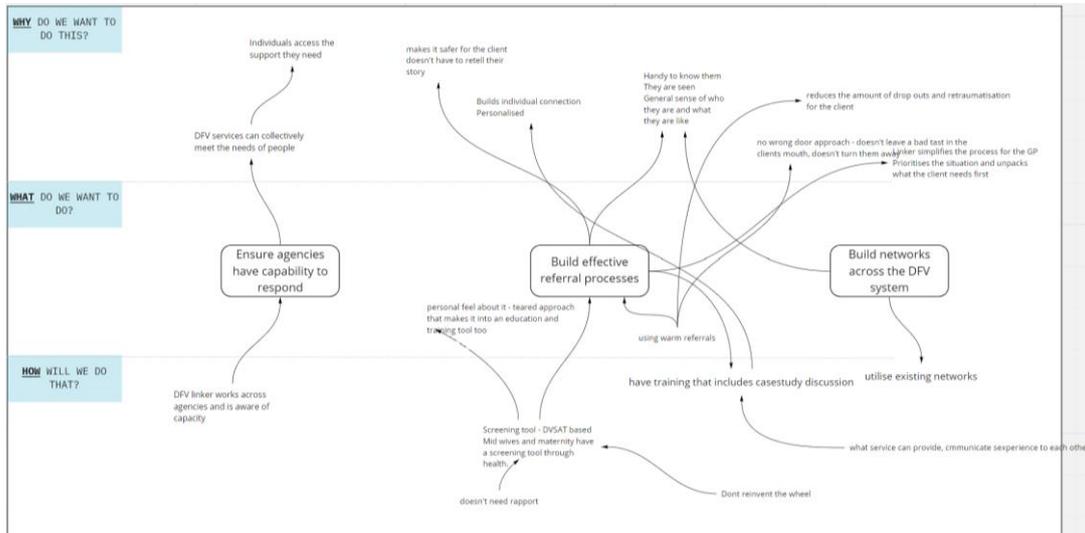


Figure 2: Example of workshop output

### 3. KEY FINDINGS

The initial questionnaire and workbook uncovered four high level themes that covered a wide range of considerations for the DFV and primary health sectors.

These four themes, displayed in the cognitive map below, are:

- **Co-ordination across services:** This focused on the need for 'warm referrals' and the importance of co-ordination and communication across services to support and 'act on' appropriate referral pathways.
- **Access:** This included access to primary care services and to DFV services.
- **Information:** A key focus of this was about ensuring GPs had the information needed to effectively refer patients to the appropriate services.
- **Training:** This focused on GPs, highlighting the need to ensure that they had the training to identify DFV and appropriately interact with their patient.

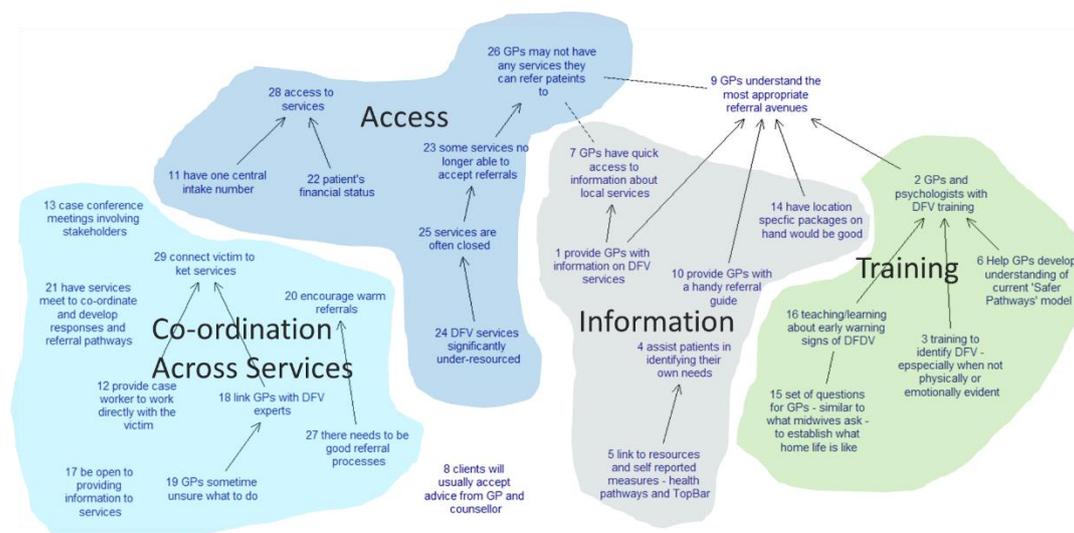


Figure 3: High-level themes from initial cognitive map

The map shows the key ideas that emerged in the questionnaire and how they link with and influence each other.

The arrows represent lines of influence. For example, one important idea was that 'GPs understand the most appropriate referral agencies' (idea 9<sup>17</sup>). The cognitive map shows four other ideas that will influence this connected by arrows. So, if we want GPs to understand the most appropriate referral sources we could 'provide GPs with information on DFV services' (idea 1), 'provide GPs with a handy referral guide' (idea

<sup>17</sup> Please note the numbers do not indicate priority or number of responses. They are simply used by the software to number the ideas.

10), 'have location specific packages on hand' (idea 14), and provide 'GPs and psychologists with DFV training' (idea 2).

Using these emerging raw themes during the workshop, the following findings section elaborates on these findings and discusses them in relation to the four main touch points of the RRR model: recognise, respond, refer and the DFV Linker.

### 3.1 Recognise

Recognise, as a part of the RRR model, addresses how primary care can be both accessible to those experiencing DFV and capable of identifying those who need DFV support.

#### 3.1.1 Findings

A key factor highlighted by the work was the access barriers faced by individuals who might use primary care to get DFV support.

Assuming an individual is willing and able to access primary care, other barriers identified include; comfort in discussing DFV with their GP, partner using the same GP, and shame and stigma of DFV. Not feeling sure that the GP could help them and not recognising that what they are experiencing is DFV were also contributing factors.

#### **Training**

Although there was an acknowledgment of time constraints, the importance of providing opportunities for GPs and other primary care staff to access additional training was emphasised. This training should focus on how to identify the early signs of DFV, the kinds of questions they could ask and how they might identify DFV, which can be very challenging. For instance, participants commented on the importance of recognising other signs of DFV including financial and psychological abuse, when there are no physical or emotional signs.

It is expected that with training and increased ability to discuss DFV, this will increase peoples comfort and trust in talking about DFV with their GP, which increases the chances of those experiencing DFV receiving support.

The DFV Linker is likely able to support this capacity building by providing advice, and identifying specific practice needs, the DFV Linker will be suitably placed to direct practices towards the most appropriate training courses to meet and build upon their current knowledge of DFV. Furthermore it was suggested that primary care and the DFV sector both contribute to training to ensure the needs of both groups are captured.

#### **Resources & information**

There was strong recommendation for primary care providers to include their services on some form of database that people know are safe spaces to talk about DFV. Other

suggestions focussed on creating awareness in patients and encouraging them to talk to their GP. For example, many participants suggested developing and displaying signposting and promotional material within clinics would reassure them it is a safe space to talk about or disclose DFV. This would also communicate that clinics are safe spaces to raise DFV and receive support.

Participants suggested that there is no need to “reinvent the wheel” as innovative ways to encourage or support disclosure already exist. This doesn’t need to be new, rather adapted from other campaigns such as the “Ask for Angela” initiative developed by NSW Police, the City of Sydney and the Australian Hotels Association<sup>18</sup>.

It is important, however, that this is coupled with information and assurance to patients about confidentiality and privacy should they disclose any DFV. GPs and health professionals are bound by mandatory reporting requirements, and especially when children are present, the threat of this can be a huge barrier that discourages disclosures. The DFV Linker should support primary care practices to develop internal protocols and patient information about what this means and how these situations should be handled. The DFV Linker should also provide advice to primary care professionals if they are faced with a situation that they do not know how to proceed with.

It is key that any consideration made for promotional material includes representation of the higher risk groups who may experience DFV including LGBTQI+, Aboriginal and Torres Strait Islander people, CALD and culturally diverse groups.

### **Screening tool**

Recognising the time constraints that GPs are already under, it was suggested that GPs need more time with patients who they suspect are experiencing DFV. This could be supported with the use of a validated screening tool. Participants added this did not need to be created specifically for DFV, rather could be adapted from the Domestic Violence Safety Assessment Tool<sup>19</sup> (DVSAT) and other examples used by midwives, hospitals etc. Moreover, and linked to the theme of training, GPs could be offered additional training in the use of such tools.

Participants felt GPs may need some additional support to become involved in this pilot, suggesting that the DFV Linker could provide some additional assistance. However, more consultation would be needed to understand what support GPs need to enable their participation in the program. Responses from GPs involved in the process, however, suggested that the program’s successful delivery would be enough incentive

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<sup>18</sup> <https://www.nsw.gov.au/news/safer-nights-out-for-patrons-roll-out-of-ask-for-angela>

<sup>19</sup> [http://www.domesticviolence.nsw.gov.au/\\_\\_data/assets/file/0020/301178/DVSAT.pdf](http://www.domesticviolence.nsw.gov.au/__data/assets/file/0020/301178/DVSAT.pdf)

## **Beyond the RRR program**

The RRR pilot should not be considered an upstream prevention program, nor is it a replacement for existing DFV programs in the region. While normalising talking about DFV in primary care will likely improve awareness, there are existing challenges the pilot will not address.

Participants highlighted these system barriers need to be addressed in the long term. The RRR model depends on those experiencing DFV choosing to, and accessing primary care, as well as wider DFV support. One issue that participants raised was the barriers in accessing primary care itself. These barriers included the cost of primary care, the partner control and surveillance often present within a DFV situation, geographical access, and perceived safety for different genders, sexualities and cultures.

Similarly, as one participant noted, the success of any program in DFV relies on overcoming the current mind-set that DFV is intractable. This requires a significant cultural and attitude shift across all sectors and stakeholders that come into contact with people experiencing DFV and those perpetrating it.

Potentially however, through increasing connections across the sector, especially the connections between primary care and DFV service providers, these barriers could begin to be addressed.

## **3.2 Respond**

Respond as a part of the RRR model addresses how primary care can support those experiencing DFV through responding to disclosures, and identifying the appropriate DFV supports for the patient's needs.

### **3.2.1 Findings**

Once a patient makes a disclosure about experiencing DFV, it is important a GP understands how to respond effectively in order to encourage and support that disclosure, and to determine what support the patient needs.

The following themes were mentioned as ways to enhance a GPs response:

#### **Information**

A common theme from the co-design process was the importance of access to information, both for those experiencing DFV and for those working in primary care.

Participants in the co-design process, including GPs, talked about how important it is for GPs to remain vigilant and aware of the prevalence of DFV as an issue, and ensure that GPs can continue to support their patients to access the services that are available to them. Participants commented that primary care should have the most up-to-date information on specific DFV services, and how to get in touch with them. This will be

discussed in greater detail in section 3.3: Refer. Therefore, once someone experiencing DFV has been identified, primary care has the right information on hand immediately to offer the patient information about and refer them onto appropriate services and ensure they get the support they require as soon as possible.

Information was also seen as important for those experiencing DFV. Participants commented that those experiencing DFV should have access to up-to-date information to help them identify whether they are experiencing DFV and supports they can access through primary care.

### **Networking**

Networking was seen to support responding to DFV through developing stronger connections between primary care and the DFV sector. There was a common perception that DFV and primary care rarely interact with each other, so there can be a lack of understanding of the different sectors of work.

Participants suggested building connections between primary care and DFV services in opportunities to network so they can share their experiences with the group. Other participants suggested having annual conferences and workshops where primary care and the DFV sector could come together, to discuss how to utilise primary care to better support those experiencing DFV. These both seek to encourage connection between primary care and the DFV sector through formal ways of working and collaborating. Participants felt face-to-face was the most beneficial mode of connecting, as this promotes relationships and confidence between the two sectors and therefore enhances referrals as well. However, with the current COVID-19 restrictions, alternatives will need to be considered.

### **Support**

Support for primary care goes beyond networking and seeks to ensure that primary care has direct and easy access to DFV Linkers. The Linker should initially provide GPs with advice and guidance when deciding how to respond to cases of DFV.

Primary care having greater access to DFV advice and therefore support agencies provides confidence in GPs responding to DFV for improved patient outcomes. This also helps the patient feel reassured and confident that the GP knows where to refer when they have access to available support agencies.

Ongoing support by the DFV sector also supports relationship building and networking between primary care and DFV agencies.

Another suggestion was for primary care practices to utilise existing internal staff meetings to discuss learnings as a capacity building opportunity where they have had a patient experiencing DFV using a confidential case conference format. This provides a safe place for all staff to support and learn from each other.

## Training

Participants suggested that some GPs may benefit from having access to additional training around the best ways to respond when someone experiencing DFV discloses their situation. Examples of training include trauma-informed training, ways of responding that are respectful, non-judgemental and supportive, including cultural and LGBTIQ+ appropriate responses. Finally, as mentioned above, mandatory reporting in relation to DFV and how to communicate this to the patient is an important consideration for primary care.

Primary care having a broader understanding of DFV and how to support individuals is important. While in most circumstances patients will likely be referred on to specialised DFV services (see section 3.3 below), there are often situations where a patient is not ready to, or is potentially unable to get support elsewhere due to their current circumstances. With the support of the DFV Linker, the RRR program enhances primary care confidence to provide continuous support to their patients on their own.

## 3.3 Refer

The final stage following recognising and responding to DFV disclosure is to facilitate an appropriate referral to the appropriate services.

### 3.3.1 Findings

It is important to note the 'refer' part of the model should be read with the following section on the DFV Linker. The Linker is a central component of the RRR program and will support primary health care professionals to refer patients appropriately.

### Service mapping

One of the key barriers currently identified as inhibiting GPs from referring patients is the lack of knowledge about service availability and capability, and the specific referral processes they support.

Participants expressed concern that current complex, cumbersome and differing referral processes place a large burden on the client. A key role for the DFV linker along with the DFV Program Development Officer will be to not only map out the relevant services but also develop simpler and more standardised referral processes. GPs are under continuous time constraints and the current state of referral processes is a likely barrier to their ongoing support and involvement.

Some stakeholders suggested creating a database with real time, up-to-date information on the available DFV and community services that can be referred to.

Participants thought that providing a service map of services, describing what they can do, and have the capacity to do, will help manage GP expectations of what services can handle.

This is especially important for services that provide support to vulnerable populations and have a reputation of doing this safely.

### **Warm referrals**

Warm referrals, where the GP contacts the service on behalf of the patient and provides the relevant information to them, is important to working in DFV. Stakeholders highlighted the importance of the program needing to support warm referrals, so a patient feels they are being referred to another *person* rather than to an *organisation*.

One way to support warm referrals is through a "no wrong door" policy. While the DFV Linker will advise the most appropriate place for clients to be referred, services need to be open to helping the individual through the system in a supportive and coordinated way, even if they are not necessarily the most appropriate service for the client. Wrong doors, or being told the service can't help you, can significantly impact the client and could lead them to disengage from all services, including primary care, before they are even provided with help.

Participants felt the introduction of a holistic referral tool that can be used by and for all services would also aid warm referrals. This should include services that provide indirect DFV support as well. The referral tool should enable clear communication and feedback pathways and removes confusion or time-consuming follow-ups. It was discussed that there is potential for existing medical software such as 'Best Practice' to be adapted to include referral to DFV services. This could be similar to how primary care may otherwise refer patients to specialist care. Several participants, including GPs, suggested that online referral templates may streamline the work that GPs would otherwise need to do and in doing so reduce their workload and make the referral process more efficient.

Warm referrals, supported by the above suggestions, will also make the process safer for clients as it reduces the amount of times they have to re-tell their story.

### **Communication and coordination**

Participants highlighted that the collaboration between DFV services and primary care could be improved. Participants felt that improving the coordination and communication channels would help to support and connect individuals to the services they require more effectively.

Some suggestions included:

- Monitoring the utilisation of existing Health Pathways for DFV, and offering refresher training if utilisation is lower than the average;
- Utilising the whole of the primary care resource, including involving the practice nurse in the referral process; and
- Developing a strong relationship with the DFV Linker.

Participants felt the DFV Linker, discussed in the section below, plays a key role in improving the collaboration between these sectors. Described as a 'conduit', participants highlighted the DFV linker role as a one-stop-shop for DFV services and support. A key benefit of this is increased coordination of care, one where people are not required to repeat their stories multiple times or have to seek new services during times of crisis. Creating this relationship, and building trust between primary care and the DFV Linker, would improve communication, client transitions between services, and build capacity in primary care.

One suggestion to increase collaboration between DFV and primary care was through two-way referral pathways. Through this, DFV services could refer individuals to GPs for medical care in the same way that primary care might refer individuals to DFV for DFV support.

Another suggestion included creating a shared database for resources and information between DFV services and primary care.

Specifically related to referrals, another key point raised by participants was that support does not stop at the point of referral. It is important, both for primary care and the DFV sector, that there is continuous engagement with the individual experiencing DFV to ensure they are receiving the right support. Particularly for primary care where GPs often have long-term relationship with their patients, there is an opportunity for them to both remain involved in monitoring the DFV over time but also being a gateway for future access to support. Importantly, the onus of communication needs to be on the services and health professionals involved, from the point of referral and throughout the patients' journey, rather than the individual utilising these services.

## **Networks**

Networking and understanding who is available to support the individual is important to improve trust and increase coordination.

Participants wanted to see face-to-face networking events, like expos, conferences or symposiums, to connect GPs, DFV Linkers and relevant DFV agencies. Participants were adamant that this should be done in person, as they believed that was the only way to increase confidence between the groups. DFV is complex and individuals seeking support are often very vulnerable. For providers, putting a face to a name and developing relationships is extremely important. Many commented this would be the most effective way to be able to build trust and feel comfortable and confident in making the referral. These sector-wide meetings could also become a platform to address and discuss system barriers that continue to pervade.

Others suggested supporting opportunities for GPs to discuss challenges faced when working with people experiencing DFV and work through case studies, learning from each other's experiences.

## Connections across the system

The need to improve connections across the system was another key theme that emerged. Everyone agreed that working with people experiencing DFV requires a multidisciplinary approach. Therefore, it is vital the RRR program works to improve these connections.

A limitation of the findings in this report should be noted. While a broad range of stakeholders were invited to take part in the co-design, more primary care involvement in the later stages of the process would enhance engagement and ensure the program was developed in a way that meets the needs of those providing support in the Nepean Blue Mountains area.

The co-design did however identify some key components that participants felt would improve system connectedness. These include:

- **Good relationships:** knowing who is behind the referral, connecting face-to-face and building trust. Face-to-face is key for building confidence for referrals.
- **Good communication:** an appropriate communication platform and referral system is paramount. Everyone involved needs to understand and support these processes.
- **Leverage off existing programs:** for example, the safer pathways model which encourages system connectedness.
- **Consistent, maintained networks:** this includes leveraging off existing networks and creating new networks, specifically across the DFV and primary care settings.
- **Overcome privacy/confidentiality issues:** all professionals involved need to understand the privacy and confidentiality involved in looking after an individual within a multidisciplinary team. There also needs to be simple, but comprehensive information sharing guidelines and protocols in place to ensure the safety of all involved.
- Develop a **shared online database** for DFV and primary care to have access to the same details.
- **Overcome funding silos:** the funding system does naturally push together like-funded services, however, this needs to be overcome to enhance collaboration.

### 3.4 DFV linker

The DFV Linker role has been described as the 'face' of the DFV services in the general practice environment. Acting as a direct referral point for GPs, they will focus on building relationships and creating a platform of trust and communication between primary care and DFV agencies, leading to improved referral outcomes. As part of their role, the Linker will also provide opportunities for further training and capacity building with general practice staff.

The co-design process sought to understand what stakeholders expected of this role, and where they should be established in order to elicit the greatest benefit.

As part of this pilot, NBMPHN has gone to market with an expression of interest to recruit three DFV linkers, one of which will be focused on supporting Aboriginal and Torres Strait Islander People, the other two positions will be region based.

The DFV linker will work with those who are experiencing or at risk of DFV and those who seek behaviour change programs. The co-design mainly focused on working with people experiencing DFV, with brief insights into what working with those seeking behaviour change programs would require.

### 3.4.1 Findings

The DFV linker is considered an important component of the RRR pilot program. The purpose of the RRR pilot is to increase the collaboration and integration between primary health and DFV agencies and improve the individual's transition between services and sectors. The DFV Linker is considered key to achieving this purpose. Specifically, participants saw that the benefit of this role was its ability to remove the "bottlenecks" of referrals. This includes referral mechanisms, which often involve labourious intake processes, complex eligibility criteria, and a lack of visibility of DFV service capacity.

Participants value the notion of a "warm handover" referral process, which could include a phone call to remove the need for cumbersome paperwork.

The co-design highlighted the need for close monitoring and review of this role to ensure it is being properly utilised by GPs and is meeting the needs of the individuals accessing help.

### **Expectations and common understanding**

The success of the DFV Linker role depends on communicating clearly the purpose of the role, how to access it, what it can and cannot be used for, its limitations, and the expectations of health professionals accessing it.

Participants acknowledged that agencies and primary care have a high workload, exacerbated by COVID-19 and to be helpful, the DFV Linker needs to be readily available to GPs and their patients. But, with such a large area for three Linkers to manage, it is important that processes are well designed and focus on high priorities.

Similarly, there was concern that the role requirements were too big. Asking a single person to act as a 'referral conduit', assist patients, give advice to those seeking behaviour change, liaise with GPs and undertake capacity building would be challenging. Participants signalled the importance of ensuring case limits and/or building structured processes around the role to avoid burnout.

The DFV Linker role needs to be established in a way that sets the role up for success, ensuring all the stakeholders and services involved have the same understanding of the role, what it is set up to achieve and how it will go about achieving it.

### **Training & capacity**

Participants highlighted the importance of comprehensive training for the DFV Linker role. Not only is this about the safety of the clients the Linker will come into contact with, but also for the Linkers' wellbeing. Many participants specifically mentioned trauma-informed training and cultural awareness and safety training.

Responses also highlighted that there will need to be a process in place for the DFV Linkers to communicate their capacity with both GPs and DFV services. Barriers or bottlenecks caused by the DFV Linker will cause providers to lose faith in the program's effectiveness.

### **Relationships & networks**

While the DFV Linker is a 'conduit' between primary care and DFV services, it is important that they also become integrated into the system, rather than remaining as an add-on support role. One participant mentioned the need for the Linker to be included in, or have specific protocols developed around information sharing, with patient/client consent. Not only is this vital for the DFV Linker to understand where best to refer the client, it also supports the client by reducing the number of times they have to retell their story.

Many participants commented that a successful Linker would have significant existing community connections and relationship, or a willingness to engage in consistent networking. Given these points, the Linker will need the ability to develop relationships with a range of services and groups, have good communication skills, and a willingness to approach and be approached by others.

The DFV Linker's relationship with the primary care practices they work with is also key. While both parties will need to work together, the DFV Linker embodies the original program's desire to "meet GPs where they are as opposed to getting them to do more"<sup>20</sup>. The Linker therefore needs to engage closely with GPs and build an understanding of the practices' specific knowledge or training needs. This would ensure any workforce training would be relevant and appropriate for that particular practice.

### **Knowledge**

For the DFV Linker to be successful, they will need to have a thorough understanding of:

- The primary health care system,
- The DFV system,

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<sup>20</sup> The Australian Centre for Social Innovation (2019), Recognise, respond, refer: An integrated health response to domestic & family violence. Developing a model for an integrated response to DFV, p.16.

- Location of services,
- Service capabilities, including what they could do for the client,
- Service capacity, including who can take on clients or who is fully booked in order to manage client expectations,
- Services specific to, or safe for, vulnerable population groups, and
- Referral systems and pathways, including how to access non-health related services such as welfare and housing.

Some suggested that collating a service directory database, potentially online, that could be monitored and updated regularly, would be useful for the Linkers.

### **Connector**

The key role for the Linker is to connect primary health care to wider DFV services. With these two systems not often intersecting participants felt careful consideration was needed to help the Linkers navigate this connection.

The Linker needs to simplify the process for the GP and, due to GP time constraints, help unpack and prioritise client needs. By doing this, participants felt they could build GP confidence in the role and the program more broadly. It was highlighted, however, that the initial engagement would require significant groundwork to show evidence of benefit to encourage GPs to stay involved.

The connection between services and across the systems with the DFV Linker acting as the conduit needs to be underpinned by a seamless and simple communication process. All stakeholders involved in this pilot will need to know who and how to contact others and who is responsible for what.

### **Location**

Deciding where the DFV Linker should be based was more contentious. While many felt they needed to be in an existing DFV service, there were some variations that are important to consider. These were:

- Some participants believed basing them in a community centre, or “neutral ground” would be beneficial so the service was not siloed into the DFV sector. This was in recognition of the multi-sectoral needs of many individuals, including housing, welfare, etc. Community centres were also promoted as discreet and easily accessible for clients.
- Community organisations are also known to have good community knowledge, linkages and relationships already in place. Therefore, leveraging those would be the most efficient.
- The Linker would need to be in a service that is accessible to everyone. While DFV services would provide useful supports, they are often run by women for women. The DFV Linker will be required to work with any individual experiencing DFV and, in some instances, will provide advice and referral to those seeking behaviour change programs.

- Others felt the Linker should be in primary care, as they are already well known to those seeking help and would keep DFV intervention at the forefront.
- Finally, some participants offered a more flexible solution, suggesting the Linker was rotated amongst many locations. This would promote their visibility amongst services and GPs.

With only three DFV Linker positions being made available, deciding where these positions should be located is difficult. However, the location they work from is less important than their job description, and ensuring that the systems put in place to allow them to perform their role are comprehensive and seamless.

### **Working with vulnerable population groups**

Aboriginal and Torres Strait Islander Peoples, CALD community and LGBTIQ+ are more likely to experience DFV and face more barriers when accessing health care support. It is therefore imperative that the DFV Linker has the knowledge, training and resources required to work with these groups safely.

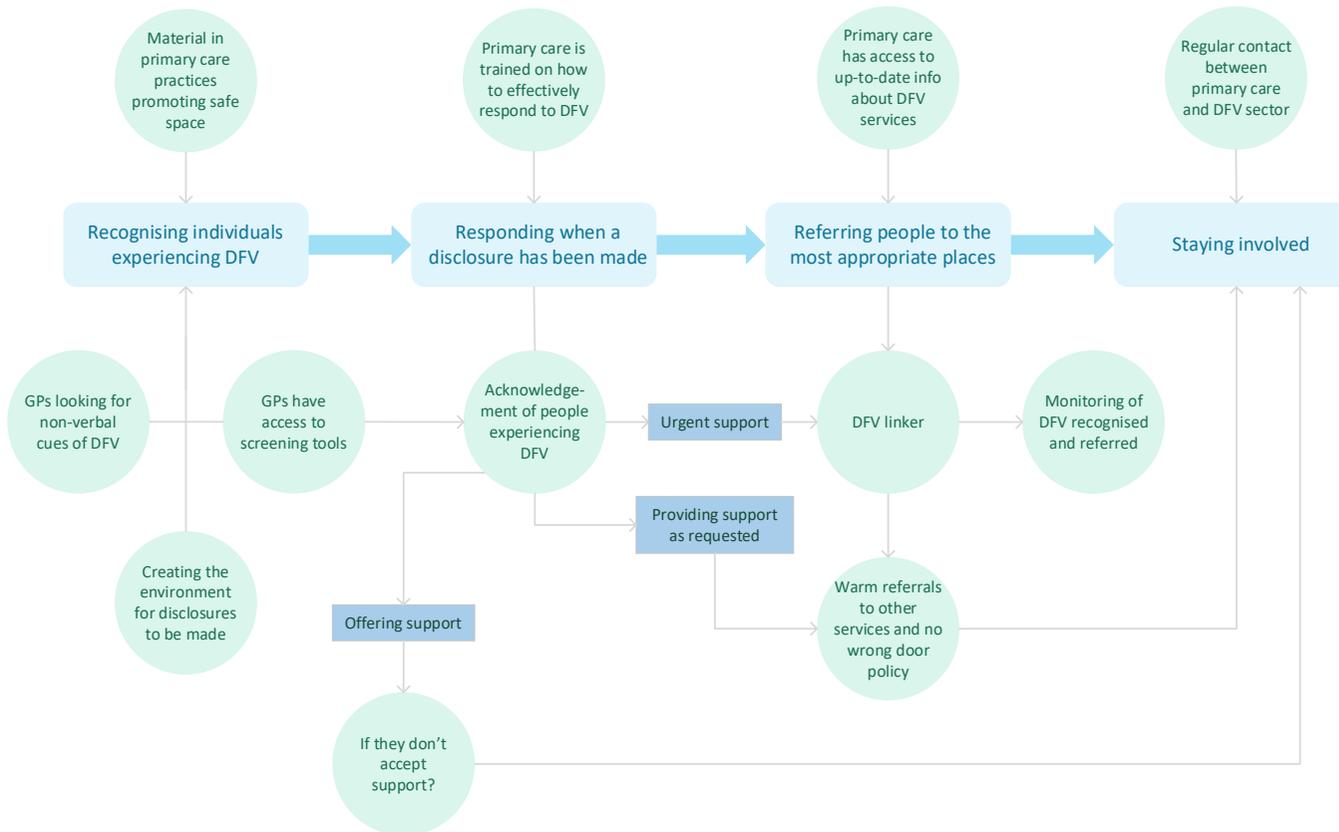
For Aboriginal and Torres Strait Islander Peoples, the DFV Linker will require cultural safety training to understand what it means to work in a culturally safe and appropriate way, for example, working from an Aboriginal specific service would be beneficial, as they are already well-known by those populations and have significant community relationships with other relevant organisations and agencies.

It will be important for the RRR pilot program to acknowledge the primary health care access barriers for these groups and recognise that this will impact the reach of the program to these populations in the first place.

A key area not discussed in much depth was how the RRR pilot is suited to CALD and LGBTIQ+ populations. Further work and consultation needs to be done by the program's steering committee to understand how the program and its components need to be designed and implemented to ensure it is both accessible and effective for these vulnerable populations.

## 4. SUMMARY OF EMERGING PILOT DESIGN

The diagram below shows the journey of an individual accessing support through this intervention in blue, the green highlights recommendations made throughout the co-design process.



## 5. IMPLEMENTATION CONSIDERATIONS: FROM A PILOT TO A SUSTAINABLE PROGRAM

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This report provides detailed information on what the RRR pilot in the NBM region needs to contain, and what the pilot needs to do if it is to achieve its goals.

While implementation was not a part of our brief, we hope that there is enough in this report to support the development of the implementation plan. To help in that process, we have written below some suggestions on how to develop the implementation plan and things that need to be considered in taking the next steps.

### 5.1 Key considerations for the PHN and pilot steering committee

What follows is a set of important questions that need to be considered in putting the detailed implementation plan together. In developing these questions, we are cognisant of the fact that this is a pilot only, with no guarantee of ongoing funding. Ensuring that progress is made on the points below will put the NBMPHN RRR pilot in a good place to secure funding and move to a more sustainable footing:

1. What is the actual work being done by the RRR pilot? Who is going to do what? The pilot program will have slightly different priorities in different communities and this need to be reflected in the implementation plan.
2. What are the essential components of the pilot? Again, the specifics of each program—including for example the training models, operational needs, tasks undertaken by the DFV linker, and integration with primary care teams—may look different depending on the community served. This needs to be clearly understood and documented.
3. What room is there for local variation? Be clear what is 'core', that is something that is standardised and consistent across the region, and what can be adjusted to local circumstances. This will be especially important in prescribing the role of the DFV linker.
4. How will the RRR pilot create value? Well-designed and implemented programs can improve health outcomes, increase access to care and support, or reduce costs; many can achieve all three at once. What value, in these terms, is this pilot going to deliver? How will you know if that value is being accrued, that is, what data do you have and what data will you collect during the duration of the pilot?
5. To whom does that value accrue, and how? Depending on the impact of the RRR pilot, the value of that impact may accrue to different actors. For example, the benefit to those experiencing DFV would be better access to and support

from those who can help them. Is there any value being accrued by primary care, by the agencies themselves?

6. What will be required to implement each component of the RRR pilot successfully? To ensure that the value is delivered it is important to establish, for each component of the RR pilot, who is required to implement it and understand what will be required to implement it successfully, For example, what do GPs and primary care need to take up the training that has been highlighted in this report as being important. Simply telling GPs that they need to be trained will not deliver the outcomes. Work needs to be done to understand, from their perspective, how to best design and implement the training so it adds value to their practice.
7. What indicators do you have that relate to this value and tell you if you are, or are not making a difference? For example, what data currently exists of people experiencing DFV accessing primary care. At a more general level, what data will tell you that you have improved *recognition* by primary care, improved *responsiveness* by primary care, and improved ability to *refer* people to the appropriate agencies. If there is no data, what processes can you put in place to start collecting that data now?