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Strengthening and sustaining the primary care response to family violence: A new Model

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THE UNIVERSITY OF MELBOURNE

The problem

Family violence is a complex problem requiring interdisciplinary collaboration to prevent and ameliorate the impact of abuse on the next generation. Family violence damages the social and economic fabric of communities, as well as the mental and physical health of individual women, men, adolescents and children [1, 2].

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

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

Further, primary care workers have an important role in early intervention as women suffering the effects of family violence typically make 7-8 visits to health professionals before disclosure [14]. Importantly, women want to be asked directly about abuse by supportive health professionals [13]. However, if women do disclose family violence to their health professional, there is evidence of some inappropriate, poor quality responses [15]. As GPs are family doctors, they also see the male perpetrator in the family and the children, although very little training is available to manage the perpetrator's role in the family.

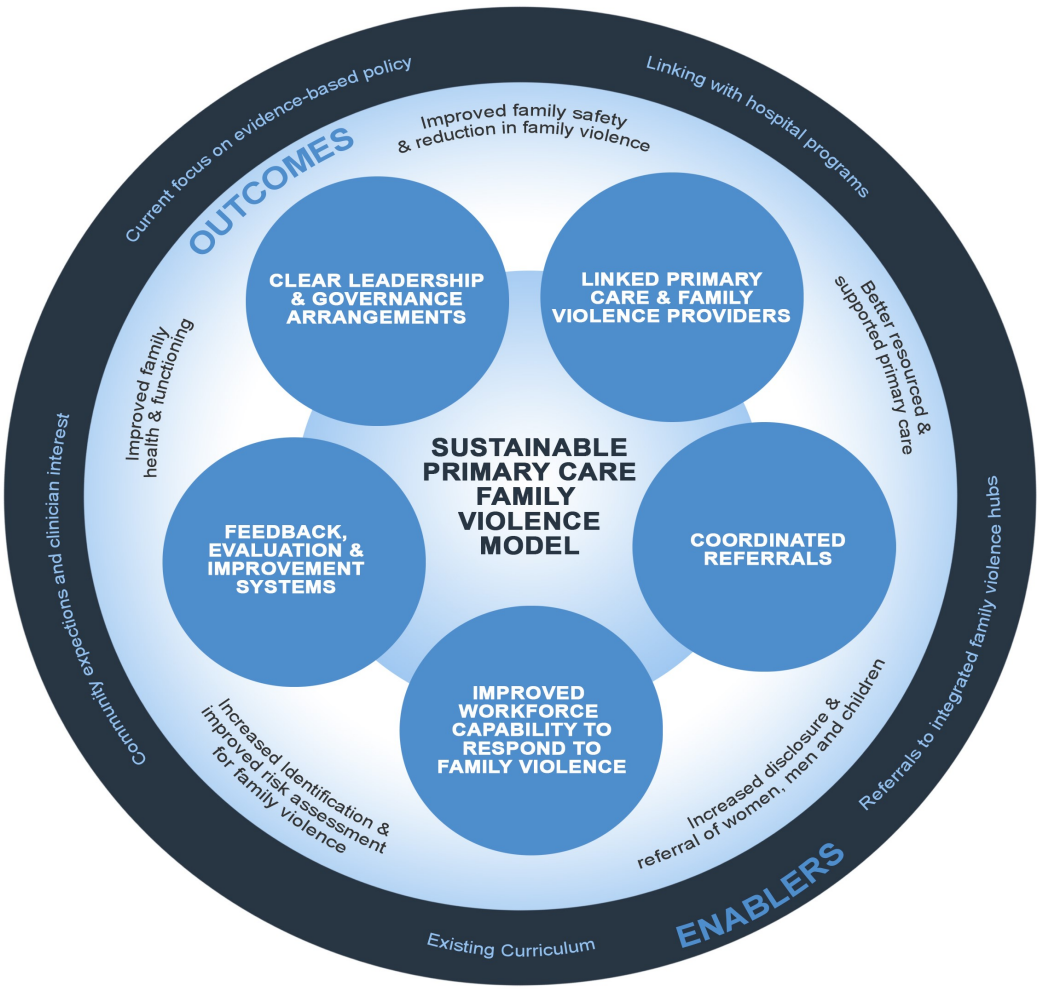
The World Health Organization (WHO) and Council of Australian Governments (COAG) have prioritised preventing and reducing the extensive damage from family violence especially on children, and identified the crucial role of an effective primary care system [3, 4].

Potential system model to address family violence response in primary care

Safer Families CRE has developed a *Sustainable Primary Care Family Violence Model* (see Fig 1) that connects with the significant program by the Royal Australian College of General Practice (RACGP) and recent work by the Australian College of Rural and Remote Medicine (ACRRM). It also aligns with work being undertaken by Primary Health Networks in parts of Australia, particularly Victoria.

Evidence of best practice informing this Model includes systematic reviews of health care interventions [16] and of qualitative studies [17], international primary care guidelines and evaluation of primary care-based family violence studies [18, 19] [20-28].

Figure 1: Sustainable Primary Care Family Violence Model



The *Sustainable Primary Care Family Violence Model* promotes integrated, interdisciplinary and sustainable supports. Key elements of the model are:

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

The evidence

There has been randomised controlled trials undertaken by investigators on the Safer Families CRE (see box below). The Model is mainly built on two primary care trials- WEAVE in Australia and IRIS in the United Kingdom.

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

What is the evidence for effective systems change in health care settings?

We know that organisational change in healthcare is challenging, but research tells us that certain types of activities are more likely to result in long-term change than others [15]. In particular, organisational change that focuses on *collective action* (the work that people do with each other, clarification of roles and resources) *and reflexive monitoring* (appraisal/feedback of the activities that are carried out) have been found to be most effective [15], compared to change that focuses on individuals. Combining such interventions is most likely to change behaviour. The evidence below is taken from recent systematic reviews from all areas of health, none in the family violence area. This has informed the development of the Model.

Potential Strategies

Persuasive

- Marketing and mass media
- Local consensus processes and local opinion leaders

What we know:

- It is hard to separate the effect of marketing and mass media as they usually occur in conjunction with other interventions.
- Local consensus processes in two systematic reviews[16, 17] showed no clear improvement in practice or patient outcomes.
- A systematic review[18] found that local opinion leaders had a positive effect on professional behaviour change but it was difficult to ascertain effect on patient outcomes.

Potential problems or considerations:

- Usually persuasive methods are not used alone so it is not always easy to sort out the effects, however local champions or opinion leaders are often recommended as part of a system change process.

Educational and Informational

- Patient mediated interventions
- Distribution of educational materials
- Educational meetings
- Educational outreach

What we know:

- Patient mediated interventions, educational materials and meetings have benefits for professional behaviour and management, with a smaller number of systematic reviews finding a benefit for patients.[19, 20] Educational outreach [21] (also known as academic detailing) is effective in changing practice of clinicians.

Potential problems or considerations:

- Training of practitioners in meeting and workshops is a standard part of systems change, although educational outreach is more likely to be effective, but has greater resource implications.

Action and Monitoring

- Audit and feedback
- Reminders

What we know:

- In a systematic review[22] audit and feedback led to improvements in professional practice and patient outcomes. Effectiveness depended on baseline measures and the method for delivering feedback. Audit and feedback may be most effective when:
    - the health professionals are not performing well to start out with;
    - the person responsible for the audit and feedback is a supervisor or colleague;
    - it is provided more than once;
    - it is given both verbally and in writing;
    - it includes clear targets and an action plan.

Computer based clinical decision support systems, computerised information systems and computerised reminders have been shown to be beneficial in improving the process of care, with some systematic reviews showing an effect on patient outcomes[23-26]. When reminders provided space for the healthcare professional to enter a response and provided an explanation for the reminder, the effect was greater than when these features were not present.

Potential problems or considerations:

- Audits need to be resourced, especially audits of patient records, whilst self-audits are variable in their quality of reporting. Computerised decision aids and reminders also have major resourcing implications, depending on the computer systems in place.

Summary

Recent systematic reviews [27, 28] showed that multifaceted strategies, particularly for complex health care areas are of more benefit. For example, interventions that link local opinion leaders, audit and feedback and reminders were the most effective. Identifying the barriers to change before implementation and tailoring to overcome these is more likely to lead to success.

Future action

The Safer Families CRE will seek funding to see if implementation of the *Sustainable Primary Care Family Violence Model* results in a more effective:

- **First line response**: Patients (victims and perpetrators) need to be responded to at the point of initial disclosure with good communication skills of active listening and non-judgmental support.
- **Safety assessment response**: Families need to have their safety assessed at the time of disclosure. Families can be guided to appropriate ongoing care, which might include the health practitioner seeing the patient for ongoing support if lower risk.

- **Pathway to safety**: Health professionals need advice and access to resources and referrals in their local areas. Where GPs identify problems or at the point of disclosure, there is a need for priority access to supports and services for high-risk patients.

The *Sustainable Primary Care Family Violence Model* will also seek funding to see if it delivers the following outcomes:

1. Better resourced and supported primary care services and health practitioners
2. Increased identification and improved risk assessment for family violence
3. Increased and more-timely disclosure and referral of women, men and children affected by domestic violence
4. Improved family health and functioning
5. Improved family safety and reduced family violence

Key enablers to support successful implementation of the system model

The *Sustainable Primary Care Family Violence Model* could be supported by a range of existing enablers in Australia. These enablers are:

Current focus on Evidence-Based Policy in family violence

There has been a significant recent investment by local, State and Federal governments to improve the general approach to reducing family violence across services. The system model is consistent with World Health Organization advice, which emphasises primary care as a suitable setting for early intervention in family violence.

Linking with Hospital Programs

There is a potential to link with the strengthening of hospital-based system models and programs for family violence. Geographic interlinking of coordination and referral activities across hospital/primary care would ensure that there are fewer victims of family violence 'slipping through the cracks' of poorly integrated responses and services.

Referrals to Integrated family violence hubs

The Model describes new and improved relationships between primary care and family violence professionals (e.g. family violence coordinators and other specialist services).

Existing Curriculum

The Model offers value by utilising existing best-practice curriculum, ensuring that there is an integrated and comprehensive approach to the training and development aspects of the program:

- The University of Melbourne's evidence-based WEAVE curriculum has been successfully implemented in several Victorian regions
- The UK Bristol University IRIS project materials are available to the CRE
- The La Trobe University Harmony curriculum has been piloted and is being tested in 2019 for South Asian patients
- RACGP and ACRRM have developed materials that can be accessed by GPs and Aboriginal health workers.

Community expectations and Clinician Interest

There has been significant increase in media reporting and community dialogue on the prevalence of family violence. This has created an increased public expectation that governments will respond appropriately and improve our response to this as a nation and within public agencies and service providers. There has been a gradual shift in professional attitudes within the health sector in response to evidence that increasingly demonstrates that family violence is not only a social and economic issue but also a significant health issue.

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