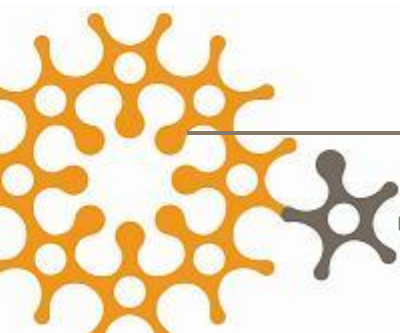
Blueprint objective	3. A health workforce that exists to serve and meet population health needs.
Case example	Sustainable Primary Care Family Violence Model
What is the community need or problem being addressed?	Intimate partner violence causes more death, disability and ill-health for Victorian women under the age of 45 than any other preventable risk factor. General practitioners (GPs) have a crucial role to play in identifying and preventing intimate partner and family violence, but they are often unaware family violence is happening. Estimates are that each GP will see up to five abused women per week without knowing they are being abused.[1] GPs have reported that they do not generally inquire about abuse because of lack of confidence, skills and knowledge of available support services.[2] Research shows as little as two hours of family violence education can be provided in medical degrees.[3] These insights suggest that Australian general practice workforce and organisational capacity to deliver a sustainable primary response to family violence may vary.
What is the approach being implemented?	The *Sustainable Primary Care Family Violence Model* aims to build and sustain greater internal capacity within primary care providers to respond to the high prevalence of family violence-related presentations in primary care settings. Research evidence, program developments and evaluation findings have informed the *Sustainable Primary Care Family Violence Model*. Key elements of the model are: 1. Coordinated referrals with clear referral protocols and pathways by engaging a network of primary care and specialised organisations to deliver a joined-up response. 2. Improved workforce capability through whole-of-organisation based support, resourcing and primary care training. 3. Feedback, evaluation and improvement systems driving constant improvement. 4. Linked primary care and family violence providers. 5. Clear leadership and governance arrangements. This model builds on a program which delivered evidence-based training to general practices in North Western Melbourne PHN (NWMPHN) catchment and expert specialist input from the University of Melbourne. The evaluation revealed GP confidence in asking their patients about family violence had improved and individual plans for clinical practice changes included: - more active questioning, including the possibility of abuse a routine in history taking (framing efforts to Start the Conversation) - openess to seeing women with family violence issues - be more attentive to signals.



What have been the key enablers to the success of this approach?	Key enablers included: ▪ The partnership approach between Victorian PHNs and the University of Melbourne, including expert Professor Kelsey Hegarty have facilitated a coordinated approach to planning, delivery and review of efforts. ▪ Strong focus on evidence-based policy and program development in family violence, and existing evidence base and curriculum. ▪ Development of localised care and referral pathways, referred to as HealthPathways. Training efforts have been coupled with the release of Intimate Partner Violence HealthPathways that have been localised for the Melbourne context and assist GPs at the point of care. ▪ Family violence is a Victorian Government Department of Health and Human Services priority with significant sector developments being implemented including the establishment of integrated Support and Safety Hubs and capability building within the hospital sector.
What have been some of the challenges to the success of this approach?	General practice training requires a strategic approach in light of competing priorities for practitioner and whole-of-practice training. There are opportunities to strategically advance and support the work of GPs in identifying and supporting disclosures of family violence within a routine consultation. NWMPHN have progressed efforts to encourage GPs to Start the Conversation with patients.
What is needed to scale-up the successes?	The *Sustainable Primary Care Family Violence Model* scales up the successes of the weave training program through providing more clinical and specialist family violence support to practices. Further training and mentoring capability will support efforts at scale. This may be complemented by enhanced links with family violence workers who offer specialist workforce capacity through secondary consultations, coordinating referrals and assisting practices navigate the family violence, mental health, AOD, sexual health and child protection services. HealthPathways are currently active across 25 PHNs or local health districts in Australia, 8 health districts in New Zealand and 1 health district in the United Kingdom. Completed pathways provide an exemplar or base pathway for use by any HealthPathways program.
More information	North Western Melbourne PHN: Website - https://nwmphn.org.au/priority-area-topic/family-violence/ Phone - (03) 9347 1188

References

[1] Hegarty, K. and R. Bush, Prevalence of partner abuse in women attending Australian General Practice: A cross-sectional survey. Australian and New Zealand Journal of Public Health., 2002. 26(5): p. 437-442.

[2] Hegarty K, Taft A. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. Aust NZ J Public Health 2001; 25:433-7.

[3] Valpeid et al. Are Future Doctors Taught to Respond to Intimate Partner Violence? A Study of Australian Medical Schools. Journal of Interpersonal Violence. 2017, Vol. 32(16) 2419–2432.

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