Role of Rural Doctors in Family and Domestic Violence

POSITION STATEMENT

College position

Family and Domestic Violence (FDV) is a complex and serious community issue which is commonly experienced by women and their children. It is disturbingly prevalent in rural, remote and First Nations communities, and has both immediate and long-term impacts on the physical, psychological and social health and wellbeing of those affected.

Tackling FDV is a shared community-wide responsibility and a major public health issue. It is beholden of rural doctors to be part of the solution.

Skills for prevention, identification and effective response to FDV are fundamental to proficient Rural Generalist and General Practice. The College seeks to support our members to build a strong professional capacity to apply best practice protocols to address all aspects of FDV both in their practice and in their communities.

Dealing with FDV can have significant personal and professional impacts on health professionals. It is important that in supporting patients impacted by FDV, doctors' and other health workers' safety can be assured and that their self-care is prioritised.

What is Family and Domestic Violence

FDV is a series of behaviours between either family members, or current or former intimate partners which can:

- include but not be limited to physical violence, sexual assault, verbal or emotional abuse, controlling behaviour, stalking, technology facilitated abuse, financial abuse and elder abuse;
- instil fear in the victim;
- be an attempt by one party to gain and retain power over another; and
- include limiting access to finances, exclusion from contacting family and friends, demeaning and humiliating behaviour, and any threats of injury or death directed at the victim or their children, family, friends or pets (including companion or therapy animals).[1]

The Rural and Remote Context

FDV is disturbingly common across all parts of Australia, impacting people of all social and cultural backgrounds. In 2022, one in four women reported having experienced violence from an intimate partner since turning 15.[2] Over 2022-23, one woman was killed on average, every 11 days by an intimate partner.[3] Additionally, over 2022-2023, there was around 220 homicide victims where domestic homicide victims made over one-third (38% or 84) in the National Homicide Monitoring Program (NHMP).[4]

The incident rate of FDV in rural and remote communities is higher compared to metropolitan settings, with remote communities experiencing the highest rates.[5]

In addition, LGBTIQA+ individuals experience family and domestic violence at higher rates compared to non-LGBTIQA+ Australians.[6]

Rural and remote contexts present a range of confounding factors related to their demographic and geographic characteristics and the impact of poorer social determinants of health. These can lead to women and children in these areas facing an especially high risk of experiencing violence and particular barriers to being able to escape.

Some specific contributing issues are likely to include:

- A lack of availability to people experiencing FDV of support services and facilities for protection, refuge, and advice and support in leaving a dangerous domestic situation including escape planning.
- Difficulty that people who do seek help may have in accessing services or escaping violence due to physical isolation and/or lack of transportation options.
- A lack of confidentiality due to the high likelihood that police, health professionals and FDV workers and staff know both the victim and perpetrator contributing to potential risk and reluctance on the part of the FDV victim to report or seek help or access support information.
- The small size and tight-knit nature of these communities, which may contribute to fear of stigma, shame, community gossip, or lack of confidence that the victim will be believed, all of which would deter or create obstacles to reporting or seeking help.

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Addressing FDV in First Nations Communities

First Nations families have a unique and profound experience of family violence which warrants strong, nuanced and community-driven solutions.

Rates of FDV in Aboriginal and Torres Strait Islander (First Nations) communities are disturbingly high and First Nations people are overrepresented as both perpetrators and victim-survivors of family and domestic violence.[7] The nature and prevalence of these incidences reflects the interplay of these communities' social and cultural structures and their post-colonial history including intergenerational trauma. It is noted that 'Family violence' is the preferred term for family and domestic violence within First Nations communities, as it covers the extended families, kinship networks and community relationships in which violence can occur.[8]

Tackling FDV in Aboriginal and Torres Strait Islander communities presents a range of specific challenges. Taking a culturally sensitive and informed approach is essential. Knowing who and where to turn to, for culturally appropriate, safe and competent services and support is a key challenge. Building strong relationships with the local community, knowing the support staff, services and networks that are available as well as wider national/regional services, is key.

This approach also applies to families from culturally and linguistically diverse backgrounds, including migrants and refugees.

The role of the RG/GP

Genuine commitment to the medical care of people in rural and remote communities should involve efforts to care for, and safeguard victims of FDV, and actively promote strategies to prevent this violence in their communities.

RG/GPs have a special role in their community compared to general practitioners in cities. They are one of only a few people available to provide medical care and without the extensive range of support services available to practitioners in urban settings. This heightens and broadens their responsibilities.

These doctors are highly visible members of their community, with relationships with patients which tend to extend beyond the practice. They are in a unique position to identify people at risk, deal sensitively with situations and coordinate responses. These interventions have the potential to empower people affected by FDV, contribute to enhanced health outcomes and potentially save lives.

As community leaders, rural doctors often hold positions in a wide range of community forums and consequently they are able to role model strong advocacy against FDV and support change within their communities.

ACRRM believes that it is part of the role and responsibility of a Rural Generalist to:

- create a practice which provides a safe place for patients who are impacted by FVD to report and seek help
- actively seek to identify patients and their families who are impacted by FDV
- provide patients impacted by FDV with appropriate medical advice and counselling
- provide patients impacted by FDV with information about support and protection that can be made available in their community
- raise public awareness of the problem and promote a positive message about violence free homes.

Teamwork, Training and Support

Teamwork

There is a uniquely important role for the RG/GP as pivotal members of the health and social service team in addressing instances of domestic violence. This role is far more important in remote and rural areas where local social services are scarce and often based in distant centres. The College advocates a multidisciplinary, multi-services team-based approach to addressing FDV wherever possible.

In all engagements with colleagues and across services in support of patients and families experiencing FDV the safety and confidentiality of those patients and their families is paramount.

Issues for Doctor Safety, Professionalism and Wellbeing

Doctors and other professionals addressing domestic violence problems in rural and remote communities put themselves at significant risk for their own personal safety. While this is true for all professionals dealing with perpetrators of violence, these problems are exacerbated by the relative geographic isolation of rural communities and the extended relationships and contacts that doctors have with both potential victims and perpetrators in their personal lives.

The issue of 'acquaintance density' in rural communities has implications for doctors as well as patients. The relationship of doctors with their patients and their families will often extend beyond their professional interactions. These create complex ethical issues for the doctor in separating their personal relationships from their professional responsibilities and also for approaches to doctor-patient communications on issues of such sensitivity as those pertaining to domestic violence. In this context, personal opinions about individuals involved in FDV must remain confidential, and not be publicised or discussed with others. Rural practitioners in both private and public facilities should seek to maintain a perception among their community that they can be trusted to provide care with confidentiality and impartiality.

Dealing with FDV issues, particularly in rural, remote and First Nations communities, can create additional stress for health professionals. It is important that self-care is prioritised, along with care and consideration for colleagues.

Both private and public facilities should be appropriately equipped to provide a safe and respectful workplace environment which minimises the potential for FDV-related incidents.

It should also be recognised that health professionals themselves can be victims or perpetrators of FDV and that appropriate workplace and collegiate support should be available.

Training and Upskilling

Effective training and professional development can strengthen the capacity of doctors to provide practical help and support to their patients and their families impacted by FDV.

Best practice training for doctors working in remote, rural and First Nations communities requires a distinctive approach. This should incorporate consideration of the confounding factors unique to these contexts, describe the best practice protocols and approaches, and the associated knowledge base for putting them into practice. The ACRRM Rural Generalist Fellowship curriculum, standards and training programs reflect this approach.

Effective education and training should build doctors' capacity to:

- Create a work setting that provides a place where people impacted by the FDV feel safe to confidentially seek help
- Identify signs of FDV in their presenting patients and their families
- Understand their responsibilities and obligations with respect to mandatory reporting
- Provide safe, confidential, and effective counselling and medical advice
- Understand the risks faced by their patients and their families experiencing FDV in the local community and ensure that advice and interactions, maximise their safety and wellbeing
- Know the full scope of FDV support resources that are available to people in their local community and build relationships with those services to optimise their capacity to support referred patients
- Implement effective strategies for promoting attitudes of FDV prevention in their community

ACRRM calls on all members to strengthen their professional knowledge and capacity to support their patients and their communities. Members are encouraged to access training opportunities and educational resources that are available to them including undertaking the College Rural Family Doctors Family and Domestic Violence Education Package. They are also encouraged to initiate their own efforts to build their knowledge of, and relationships with services and service providers available to patients and families in their community.

Endnotes

1. Australian Institute of Health and Welfare (2018) Family, domestic and sexual violence in Australia, 2018, AIHW, Australian Government, accessed 28 November 2024. doi:10.25816/5ebcc144fa7e6
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3. ABS (Australian Bureau of Statistics) (2017a) Personal safety, Australia, 2016, ABS website, accessed 22 February 2023.
4. Miles H and Bricknell S (2024) Homicide in Australia 2022–23, AIC, accessed 2 May 2024.
5. Women's Services Network (WESNET), Domestic violence in rural Australia: a literature review, Department of Transport and Regional Services, Canberra, 2000, accessed 30 June 2014.
6. Royal Australian College of General Practitioners. (n.d.). LGBTIQA+ Family abuse and violence (5th ed). https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/specific-populations/lgbtiq-family-abuse-and-violence.
7. Cripps K (2023) Indigenous domestic and family violence, mental health and suicide, AIHW, Australian Government, accessed 26 May 2023.
8. Cripps K and Davis M (2012) Communities working to reduce Indigenous family violence Indigenous Justice Clearinghouse, accessed 16 May 2023.

Find out more

If you have any queries relating to this Position Statement, please contact us by:

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.