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Knowledge and practices of regional and rural general practitioners in the identification and management of intimate partner and family violence: a mixed methods study in Western Australia

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Abstract

Background General Practitioners (GPs) are well placed to identify and assist patients experiencing intimate partner violence (IPV) and family violence (FV). However, patients experiencing IPV/FV can be under-detected or inadequately assisted when GPs do not have the necessary confidence, knowledge, attitudes or skills for this. Given the high rates of IPV/FV in the Australian regional setting where this study was conducted, this investigation explored the confidence, knowledge, attitudes and practices of local GPs in identifying and managing patients who are experiencing IPV/FV.

Methods This mixed methods study utilised a survey tool adapted from a review of existing instruments. The adapted tool included questions on provider confidence, knowledge, attitudes and practices for quantitative analysis, as well as open-response questions that were analysed thematically. All GPs ($n = 58$) working within the area at the time of the study were invited to participate via emails and written letters distributed through practices and at pre-existing meetings, with 25 completing the survey (43% response rate).

Results Participants lacked knowledge around GP-facilitated disclosure of abuse, many believing the patient to be the main reason for non-disclosure. Half or fewer respondents indicated confidence in creating safety plans with patients, in making appropriate referrals and in identifying IPV/FV by history, signs and symptoms. There were mostly favourable attitudes towards asking about and assisting with IPV/FV, although only one quarter of respondents believed that individuals experiencing IPV/FV can make appropriate choices about how to handle their situation. In terms of practice, only one third agreed that they could match interventions to patient readiness to change. Other key concerns included difficulties in accessing timely support, with improved coordination of local services and systematic changes in the GP environment being the most common recommendations made by respondents.

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Conclusions This study demonstrated that the responding GPs in a regional area with high rates of IPV/FV have generally favourable attitudes towards identifying and assisting with IPV/FV but lack knowledge and confidence in the practical elements of enquiry. Surprisingly for a regional area, there was poor understanding of local support provision. The findings have the potential to meaningfully inform regional and rural primary care experiences, including desired educational opportunities and enhancing the relationship between health professionals and relevant community organisations. The results support the need for upstream changes in the general practice environment to improve the ability of regional and rural GPs to build relationships with patients over time and enhance overall health outcomes for those affected by abuse.

Keywords Domestic, Family, Violence, General, GP, Primary, Practice, Identify, Manage, Rural, Regional

Background

Family Violence (FV) and Intimate Partner Violence (IPV) are under-identified public health issues with serious long-term implications for the health and wellbeing of those experiencing violence, their families, and the wider community. Whereas FV is a broad term that encapsulates violence between family members as well as intimate partners, IPV refers to behaviours within an intimate relationship [1, 2]. IPV/FV can involve acts of physical violence, sexual violence, emotional abuse, social abuse, financial deprivation and many other coercive and controlling behaviours.

Women are significantly overrepresented in IPV/FV statistics with 1 in 4 Australian women and 1 in 8 men having been subjected to these forms of violence since the age of 15 [3, 4]. However, these figures will be underestimates due to the known issue of underreporting [1, 4]. Although the underlying causes of IPV/FV are poorly understood, gender inequality is a key underlying driver of violence against women, with alcohol and drug abuse by perpetrators often associated with increased frequency or severity of the violence [1, 2].

Women in rural areas experience even higher rates of IPV/FV, with hospitalisation rates in remote areas 24 times that in major cities, and 32 times more likely for Indigenous compared to non-Indigenous Australians [5]. Several considerations are pertinent when thinking about IPV/FV in the context of a rural or regional setting. Firstly, specialist IPV/FV support services, including safe houses and rental properties, are less readily available making it more difficult for those affected to safely leave an abusive relationship. Restraining orders are more difficult to implement and enforce in rural and regional areas, given limited policing and longer emergency service response times [6–8]. The underlying social structures of rural and regional areas differ to those in metropolitan areas, including less anonymity, confidentiality and privacy when attending services than may occur in large population centres; this risks shame and fear, particularly where many people know the perpetrator [7–9]. Victim/survivors may be more dependent on their partners financially, particularly if there is a lack of childcare, a shortage of jobs and training opportunities, a lack of housing availability or limited public transport. Community attitudes are often directed at 'getting on with things' with an emphasis on maintaining the wellbeing of the family. In some communities, violence can be 'normalised' or go completely unnoticed due to isolation or the ease of surveillance by perpetrators [8].

Existing literature on general practice identification and management of IPV/FV

Experiences of IPV/FV are disclosed in General Practice settings [10]. However, many victim/survivors do not present directly, instead presenting with a variety of medical or social issues ranging from physical injury and chronic non-specific symptoms to psychological concerns [10]. There are generally thought to be two types of disclosure in the healthcare setting – patient-led and clinician-led [11]. Patient-led disclosure occurs where a patient decides to attend a GP to seek help for IPV/FV or sees other prompts such as practice posters which encourage disclosure. Clinician-led disclosure occurs where a GP asks directly or indirectly about experiences of IPV/FV. Clinician-led is the most common type of disclosure in the primary care setting and studies have repeatedly indicated that the issue of IPV/FV needs to be raised by health professionals to make it easier for the patient to disclose [12–16]. Even when asking about IPV/FV does not lead to a disclosure, the process of asking can let the patient know that the clinician is open to discussing such concerns if and when the patient is ready to do so [17, 18].

Not only do GPs need to be sensitive to enquiring about IPV/FV, they also need to be ready to respond to patient disclosure in a helpful and supportive manner. GPs have a vital role in listening to the patient, acknowledging abuse, and validating that violence in relationships is not acceptable [17]. Naming the issue in itself can be a powerful first step. Clinicians need to be able to assist and support the patient physically, psychologically and socially. This may involve appropriate referral to other multidisciplinary agencies and safety planning. Conversely, negative experiences of disclosure may prevent victim/survivors of abuse from seeking assistance in the future.

Despite the benefits of IPV/FV disclosure in a primary care setting, IPV/FV is often under-detected in health settings for a myriad of reasons related to patient and practitioner barriers. Patient barriers are most commonly psychological, social and service barriers, with examples of each given in Table 1. The evidence regarding patient barriers is strong, including a systematic review and two meta-analyses. However, none of these studies specifically focused on the barriers for patients in regional and rural areas which may be different to the barriers faced by patients in metropolitan areas.

These reported patient barriers need to be interpreted in the context of the barriers that GPs commonly describe in discussing and managing IPV/FV. Although there is ample research published on a wide variety of GP-related barriers to the identification and management of patients experiencing IPV/FV, we did not identify studies that focused specifically on the regional and rural experience. Given that general practice in rural areas presents many additional challenges, this represents a concerning gap in the evidence.

Multiple studies suggest that inadequate training and knowledge is a key barrier for GPs [24–31]. When given the appropriate training, GPs report greater feelings of preparedness, comfort and confidence in broaching the topic of IPV/FV with patients [27]. Having adequate communication skills around IPV/FV are also critical for enhancing disclosure [32].

Studies from multiple contexts show that GP time constraints are a significant barrier [24, 25, 27–31]. IPV/FV requires more time to explore than many other health issues. The time taken to appropriately manage a disclosure in a GP consult may therefore be one of the reasons it is not asked about.

A GP's attitudes and beliefs can influence their ability to identify and respond to IPV/FV. Some of these include fear of offending the patient or invading their privacy, fear of making things worse for the patient, personal discomfort or believing that it is not within the boundaries of their role [30, 31]. Some GPs may express feelings of helplessness or frustration due to perceived ineffectiveness in assisting patients to make changes to their situation after disclosure, while others may believe that abused women are at least partly to blame for the ongoing abuse if they do not leave [28, 29, 31].

Purpose of this study

Despite the difficulties, rural and regional communities are generally well placed to work collaboratively at a whole of community level to both prevent IPV/FV and to provide help to those who are experiencing violence. The regional area where this study was conducted has a population of approximately 39,000, including 9.7% who identify as Aboriginal [33]. The region has the second highest rate of IPV/FV incidents reported to police in Western Australia [34]. Rates of reported assault by a family member are more than twice the state rate and more than three times the Perth metropolitan rate [35]. The regional city has a local IPV/FV primary prevention campaign in place, which includes a collaborative communication strategy, local workplace messaging, and bystander training focusing on disrespect and gender inequality in the workplace. Given collaborative initiatives to raise awareness of IPV/FV within the community could potentially lead to higher rates of help-seeking by those affected, community services need to be available to respond. There is also a local organisation that offers services for women and families including women's health services, sexual assault services, IPV/FV response and crisis accommodation for women and children. The service provides advocacy and assistance for people experiencing IPV/FV, which can include counselling, safety planning, referral to other organisations for social supports, and applying for restraining orders.

GP recognition and management of IPV/FV in Australian rural and regional general practice is under-researched, with limited data on the barriers and enablers of GPs in these settings and their educational needs. Given the high rates of IPV/FV within the regional and rural setting in which this work was undertaken, this study aimed to investigate the confidence, knowledge, attitudes and practices of local General Practitioners in

Table 1 Examples of reported patient barriers for victim/survivors experiencing IPV/FV in seeking help from health professionals [12–16, 18–23]

Psychological & Emotional	Social	Service
Low self-esteem, depression and anxiety – patient feels unable or too uncomfortable to disclose Normalisation of violence, denial or lack of insight that a problem exists Feeling controlled and having fears about how the service would use the information to further 'control' them	Social isolation - lack of family or social supports to enable changes Social control and coercion by the perpetrator – unable to see a healthcare provider alone or perpetrator blackmail around disclosure Concerns of social repercussions of disclosure, such as housing, child removal and finances Prioritising family cohesion over their own safety	Lack of access to service attendance – physical or financial GP not asking about IPV/FV, and the patient needing an 'enabler' to disclose Previous negative experience of disclosure, such as experiencing blame or judgement, or lack of a trusting relationship with provider Healthcare services having a focus on the physical and psychological causes of illness rather than addressing underlying social causes

identifying and assisting patients who are experiencing IPV/FV. This will inform future initiatives to improve GP education, identification and management of IPV/FV, with the hope of enhancing both the detection and support offered to those experiencing violence within this setting.

Methods

This mixed methods study utilised a questionnaire developed following a review of existing instruments in the literature. The intention of the instrument development was to capture General Practitioner preparedness to work with patients experiencing IPV/FV, including provider confidence, knowledge, attitudes and practices.

The final items used in the questionnaire were generated mainly from a survey tool developed by Short (2006) called the PREMIS (Physician Readiness to Manage Intimate Partner Violence Survey), a validated 67-item questionnaire which showed good correlation with measured office IPV practices, including on repeat testing [36]. The original tool was discussed within the research team and adapted over multiple iterations to suit the local context. Brevity and respondent burden were considered of the highest importance given advice from a local GP (AG) that a survey taking any longer than 15 min was unlikely to be completed. The final adapted survey consisted of six demographic items, 37 structured items and optional open-response items, including items on training, confidence, knowledge, attitudes, opinions and clinical practice. The full questionnaire is provided as a supplementary file (Additional File 1.pdf. – GP Survey on Responses to Family Violence, complete survey).

The open-response questions included: 'What do you experience as barriers to discussing and identifying IPV/FV?', 'What are the main challenges you have managing patients who are experiencing IPV/FV in your daily practice?', and 'What would you recommend in order to improve the care of patients experiencing IPV/FV in General Practice settings?'. These questions were deemed important as Leung (2017, 2018) identified that GP 'readiness' to identify and respond to IPV/FV may include additional factors that are not included in the PREMIS such as self-efficacy, motivational readiness and emotional readiness [37, 38].

The survey was reviewed and trialled by the research team and a local GP prior to finalisation to ensure that the questions were relevant and coherent, while sufficiently brief to ensure an adequate response rate.

Eligibility and questionnaire distribution

All GPs including GP Registrars working within the regional town (identified in the WA Primary Health Alliance Local Health Service Directory, August 2020) were invited to participate in the study. The survey was advertised and distributed to local GPs via email, practice visits, word-of-mouth and GP network meetings. GPs were given the choice to complete the anonymous questionnaire either online on the Qualtrics platform or on hard copies.

Data analysis

After the closing date of the survey (September 2020), data were downloaded to statistical analysis software IBM SPSS for analysis. Comparisons in item responses were made by demographic subgroups. Where there were incomplete item responses the denominator has been altered to account for this.

A thematic analysis was undertaken of the open-response answers for each question and across questions. This involved collation of the responses to each question, coding, and identification of emerging themes by three authors (CC, ST and HG). Collaboration and communication within the research team were used to refine and strengthen the themes and enhance credibility of the findings. The quantitative results were considered in conjunction with the open ended response analysis, with researchers identifying common and complementary threads as well as any contradictions and discrepancies between quantitative and qualitative responses. Reflexivity was demonstrated in both the design of the survey and promoting it to GPs, and in the analysis, as the researchers were all aware of their role as health professionals and of the small size of the medical community in the regional city. We were aware of the sensitive nature of asking local GPs about their knowledge, attitudes and practices around IPV/FV and the need for constructively analysing and reporting on the research.

Ethics approval

This research project was approved by the Human Research Ethics Committee of the Human Ethics office at The University of Western Australia (UWA) (Project Number RA/4/20/5878). All approvals occurred under the principles set out in the National Statement on Ethical Conduct in Human Research (2007) (the National Statement), and the University's policies, terms of reference, and constitutions. Informed consent was obtained from all participants in the study. There were no financial or other incentives for the completion of this questionnaire.

Results

Survey completion and demographics

Twenty-five respondents completed the questionnaire. Of these, 18 respondents offered additional input by completing all optional open-response questions and 13 respondents offered additional insight on their views around further IPV/FV education.

The respondents consisted of 16 out of 42 qualified General Practitioners (38%) and 9 of 16 (56%) General Practice Registrars (doctors currently in GP training) practicing in the region at the time of the survey (WA Primary Health Alliance Local Health Service Directory, August 2020). This equated to an overall response rate of 43%. Hereafter, responses from both qualified General Practitioners and General Practice Registrars are aggregated and referred to as 'GPs' unless otherwise specified.

Of the respondents, 64% (*n* = 16) were female, with 60% (*n* = 15) aged 30–49 years and 40% (*n* = 10) aged over 50 years. In terms of experience, 64% (*n* = 16) of respondents were qualified GPs and 36% (*n* = 9) were GP registrars. The year of medical qualification for the participants ranged from 1980 to 2016, with a median of 2001. Hours worked per week (at the time of the survey) ranged from 4 h to 90 h, with a median of 40 h.

Postgraduate training in IPV/FV

Since graduating, around a quarter (28%) of respondents reported that they had not received any postgraduate training (PGT) about IPV/FV. For the 72% who had completed any PGT in IPV/FV (*n* = 18), 61% had attended a workshop or talk by a local organisation, 39% had read 'Abuse and violence: working with our patients in general practice - the White Book' of the Royal Australian College of General Practitioners (RACGP) [39], 28% had completed the RACGP online family violence education modules and 28% had attended training in their workplace setting.

Confidence, attitudes and practice

Confidence with assessing and responding to IPV/FV

Overall, GPs were most confident with asking appropriate questions when they suspected a patient was experiencing IPV/FV (64% confident/very confident) and documenting relevant information in the medical records (60%) (Table 2). GPs were least confident (less than 50%) in helping a patient who has experienced IPV/FV to create a safety plan (42%) and in making appropriate referrals (48%). Only half of the respondents felt confident or very confident in identifying history, signs and symptoms associated with IPV/FV.

Confidence levels were generally similar between GP registrars and qualified GPs (Table 2). The largest difference was in assessing the risk to a patient who discloses IPV/FV (47% GP; 67% GP Registrar), with GP registrars feeling more confident in this area.

GPs who had attended at least one PGT session on IPV/FV were more likely to feel confident in assessing the risk to a patient who discloses IPV/FV (14% of those without PGT; 71% of those with PGT), in identifying signs and symptoms associated with IPV/FV (14% no PGT; 65% with PGT) and in helping a patient to create a safety plan (14% no PGT; 53% with PGT). These two groups were similar in their confidence to make appropriate referrals (43% no PGT; 50% with PGT).

Attitudes, opinions and practice

Overall, GPs did not feel that adults experiencing abuse are responsible for the violence if they choose to stay in a violent relationship (4%), and most were not reluctant to ask about IPV/FV due to treating the patient's partner or family members. No respondent reported being reluctant to ask about IPV/FV for fear of offending the patient or making matters worse, or due to feeling that it is a private matter. Overwhelmingly, GPs did not report that time prevented them from asking about IPV/FV, with only one respondent (4%) reporting this. However, only one quarter (24%) agreed that individuals experiencing IPV/FV can make appropriate choices about how to handle their situation, with GP registrars more likely to agree (13% GP; 44% GP Registrar). One in five GPs (20%) were concerned about their legal obligations if a patient were to disclose IPV/FV.

The largest differences in practice among those who had received any postgraduate IPV/FV training were seen in believing that they could match interventions to a patient's readiness to change, with 39% who had attended postgraduate training feeling that they were able to do this compared to 14% who had not participated in any postgraduate IPV/FV training (32% overall).

Children presenting with unexplained signs or symptoms had the highest proportion of GPs asking about IPV/FV, with 79% always or nearly always asking in these circumstances. Less than one third (29%) of GPs always or nearly always asked about IPV/FV when seeing pregnant women.

Most GPs had identified a patient or patients experiencing IPV/FV within the past 6 months, with only two answering that they had not. The most frequent action taken by GPs after identifying a patient experiencing IPV/FV was counselling the patient regarding potential options (80%) and providing information in the form of phone numbers or pamphlets (68%). Just under half (44%) helped the patient to develop a personal safety plan and 60% made referrals to local services.

Knowledge of IPV/FV

Most respondents believed that the strongest single risk factor for experiencing IPV/FV was being female (55%), closely followed by having a partner who abuses alcohol or drugs (41%).

GPs were highly aware that it is safest to see a female patient without her partner present if she presents with signs or symptoms of IPV/FV (96%) and that pregnant women are at a higher risk of experiencing IPV/FV (84%)

Table 2 Overall results in confidence and attitudes, disaggregated by postgraduate training experience and level of training

	Total (All)	**No PGT in IPV/FV**	**Attended PGT in IPV/FV**	**General Practitioner**	**GP Registrar**
	% Confident / Very Confident	**% Confident / Very Confident**	**% Confident / Very Confident**	**% Confident / Very Confident**	**% Confident / Very Confident**
Confidence					
Asking appropriate questions if you suspect a patient is experiencing IPV/FV	64	43	72	63	67
Appropriately responding to disclosures of IPV/FV	56	29	67	50	67
Identifying history, signs and symptoms associated with IPV/FV	50	14	65	47	56
Assessing the risk to a patient who discloses IPV/FV	54	14	71	47	67
Helping a patient who has experienced IPV/FV to create a safety plan	42	14	53	38	50
Documenting IPV/FV history and findings in the medical records	60	43	67	63	56
Making appropriate referrals for a patient who has experienced IPV/FV	48	43	50	50	44
	% Agree / Strongly Agree	% Agree/ Strongly Agree	% Agree / Strongly Agree	% Agree / Strongly Agree	% Agree / Strongly Agree
Attitudes					
If an adult who has experienced IPV/FV remains in the relationship after repeated episodes of violence, they must accept responsibility for the violence.	4	14	0	6	0
Individuals who are experiencing IPV/FV can make appropriate choices about how to handle their situation.	24	14	28	13	44
IPV/FV is a private matter and as a health professional I should not interfere by asking about it if the patient does not directly disclose.	0	0	0	0	0
It is not acceptable for me to ask about IPV/FV if I also treat the patient's partner or family members.	4	0	6	0	11
Practice					
I do not have time to ask about IPV/FV.	4	14	0	6	0
I am reluctant to ask about IPV/FV because I might offend the patient or make matters worse.	0	0	0	0	0
I am concerned about my legal obligations if a patient were to disclose IPV/FV.	20	14	22	19	22
I can match interventions to the readiness to change of a patient who has experienced IPV/FV.	32	14	39	31	33

Table 3 Overall knowledge responses of gps regarding IPV/FV

Knowledge Questions: **Please respond 'True', 'False' or 'Don't Know' for the following statements:**	**% Answering 'True'**	**% Answering 'False'**	**% Answering 'Don't Know'**
Women who have experienced IPV/FV are at a greater risk of injury when they leave the relationship.	58	29	13
If I am suspicious that a female patient has presented with signs or symptoms of IPV/FV, it is safer to arrange to talk to the patient without her partner present.	96	4	0
Gender inequality is the underlying driver of violence against women.	54	33	13
Pregnant women are at higher risk of experiencing intimate partner violence.	84	0	16

(Table 3). There were lower levels of knowledge that women are at greater risk of injury when they leave a relationship (58%) and that an underlying driver of violence against women is gender inequality (54%).

Only one in five GPs (21%) felt that they had adequate knowledge of IPV/FV referral resources in the community. The most frequent organisation patients were referred to by participants ($n = 13$) was a local organisation that offers services for women and families including women's health services, sexual assault services, IPV/FV response, crisis accommodation for women and children and primary prevention. This was closely followed by referrals to mental health services ($n = 12$) or to helplines/websites ($n = 10$).

Analysis of open-response questions

There were 23 respondents who provided comment in response to the open response questions and 18 completed all open-response questions.

Referral resources

Participants commented that it is hard to keep track of services which keep changing and that there needs to be improved communication with local GPs about the services available along with more practical support for victim/survivors.

'Found resources too scattered and not a central referring point - too many different organisations to help - not co-ordinated.' (General Practitioner, 30 years after graduation).

Barriers for GPs to discussing and identifying IPV/FV

In response to the question '**What do you experience as barriers to discussing and identifying IPV/FV?**', nine GPs gave specific examples of patient-related barriers. These included patient fears such as shame, escalating the violence, putting their partner or their relationship at risk, incurring costs, privacy violations and not being believed.

Eight respondents cited time as a barrier, while five commented on their lack of skills, knowledge and experience. Other difficulties described were with establishing rapport and trust, needing to address other issues during the consultation, and their troubles with finding suitable services for patients who disclose.

> *'Inability to follow up, build trust, therapeutic relationships. Often people see a GP they can get in to, able to access often for a different presenting complaint. When it is safe or asked directly IPV is disclosed. This requires time, careful consideration and ability to see your patient for follow-up.' (GP Registrar, 5 years after graduation).*

Barriers for GPs in assisting patients experiencing IPV/FV

Responding to the question '**What are the main challenges you have managing patients who are experiencing IPV/FV in your daily practice?**', nine respondents noted challenges with access to resources and services, and eight respondents cited a lack of time.

> *'Not having the time to deal with it properly. Lack of understanding of resources available.' (General Practitioner, 40 years after graduation).*
> *'Time, lack of resources that will take my call ASAP to help get patient the help they need.' (GP Registrar, 6 years after graduation).*
> *'Lack of referral facilities and knowledge of support groups in the community.' (General Practitioner, 26 years after graduation).*

Other respondents reported a reluctance by patients to discuss their experiences or to make changes, exemplified by this response.

> *'Getting her to accept change. Making a decision.' (General Practitioner, 13 years after graduation).*

Difficulties following up patients who disclose experiences of violence was an issue. One respondent likened it to 'opening a flood gate' and needing additional follow-up because a standard appointment was insufficient but continuing the consult at another time seemed disruptive, with patients having barriers to attending arranged follow-up appointments.

> *'Time factor. Almost always opening a 'flood gate', then needing another appt [appointment] to ct [continue] consult (disruptive for patient, may not return because of this).' (General Practitioner, 31 years after graduation).*

Several respondents mentioned a lack of appropriate funding for GP and other services as a challenge to effective management. Feeling 'hopeless' and unable to help as a GP was cited as a challenge by one respondent.

> *'Challenging area can feel hopeless/like you can't totally help as the GP, often financial issues keep women in the situation.' (General Practitioner, 11 years after graduation).*

Recommendations by GPs for improving the care of patients experiencing IPV/FV in primary care settings

Specific IPV/FV education recommendations were made by respondents, including suggestions that training by someone with lived experience, information on GP rights and responsibilities, brief interventions, communication training and safety would be valuable.

Several recommendations for improving the care of patients experiencing IPV/FV in local general practice settings were made which related to better coordination of services, support and the provision of information.

> *'Proper central coordinating centre to direct clients to appropriate help'.(General Practitioner, 30 years after graduation).*
> *'Patients actually need a support person to navigate health system, get to appointments, liaise with multiple organisations'. (General Practitioner, 28 years after graduation).*
> *'Inform GPs of all available resources in town'. (GP Registrar, 23 years after graduation).*

Systematic changes in the GP environment were also recommended.

> *'Better time based Psych. Mental Health items, reduction of paperwork required for clear Mental Health referrals'. (General Practitioner, 27 years after graduation).*
> *'More routine scheduled preventative health screening – we prompt to ask about breast health/breast screen/flu vaccines. We should be having more automated prompting to screen for relationship difficulty, stress, IPV - this would assist normalising, creating conversations, prompting GPs to consider'. (GP Registrar, 5 years after graduation).*

Discussion

The challenges and practices of regional and rural GPs with respect to identifying and assisting patients experiencing IPV/FV have received little specific attention. While there are similarities with that described in other research exploring the experiences of GPs in metropolitan areas, this study gives several important insights into regional and rural GP enablers and barriers around IPV/FV enquiry and management.

The low rates of confidence and knowledge in assisting patients with safety plans and making appropriate referrals is an important finding in conjunction with many respondents not feeling that they can match interventions to the patient's readiness for change. The low number of respondents with knowledge that women are at greater risk of injury when they leave a relationship also aligned with GPs' lower confidence levels in creating a safety plan, as this is an essential element of knowledge required for creating such a plan. As this increased risk of injury includes an increased risk of homicide during this time period, it is especially important that GPs are aware of this fact and take it into consideration in the decision-making process [39]. However, the impact of IPV/FV training on these parameters was evident, with GPs who had attended at least one postgraduate training session on IPV/FV more likely to feel confident in a wide range of practical elements, including safety planning and matching interventions to patient readiness. The breadth of potential educational areas identified by respondents shows an understanding that addressing IPV/FV in general practice requires knowledge as well as practical skills. Practitioner education alone does not significantly increase identification rates, but interventions that also incorporate practical strategies and skills are associated with increases in IPV/FV identification [30]. For example, the WEAVE study [40] showed that GPs trained in active listening, motivational interviewing and problem-solving techniques enquired more about the safety of women [40]. This indicates a need for more hands-on training in the practical management of IPV/FV, particularly tailored to the local regional context. Tailoring to the local context is important because unfamiliarity with or a lack of trust in community-based agencies have been shown to raise doctors' stress levels and potentially create a reluctance to identify patients experiencing abuse [29]. However, even though most GPs who reported postgraduate training had attended a local event (suggesting that local training events are important for regional and rural GPs), respondents who had and who had not received IPV/FV postgraduate training were most similar in their confidence to appropriately refer patients experiencing IPV/FV. We can speculate that this may be because the courses were not adapted to the local context or that referral pathways change without adequate information being provided to local GPs. Many courses offered in regional areas are written and delivered by those working in metropolitan centres, sometimes without inclusion of local speakers. Locally developed and run courses are less common, requiring more intensive work for local organisations, but they may result in more adequate and relevant adaption and contextualisation of information for the local services and community.

The additional finding that registrars were more likely than GPs to feel confident to respond to disclosures of IPV/FV and to assess the risk to a patient who discloses IPV/FV was interesting. The reasons for this are unclear, with potential factors ranging from the naivety of inexperience through to enhanced knowledge due to changes in contemporary training curriculums or the recency of their study.

Most respondents identified that the strongest single risk factor for experiencing IPV/FV was being female, closely followed by having a partner who abuses alcohol or drugs. Drugs and alcohol are known to increase the frequency and severity of violent behaviours through reducing inhibitions. However, it is important that drug and alcohol use is not seen by GPs as an 'excusing' factor or the main cause of violent behaviours in relationships as this may alter or reduce the help and support offered to victim/survivors.

Interestingly, although most GPs were aware that pregnant women are at a higher risk of experiencing IPV/FV, only a third asked about IPV/FV when seeing pregnant women. This may be for a variety of reasons, including their own judgement that IPV/FV is unlikely, but it implies that knowledge alone is not enough to prompt enquiry about IPV/FV. GPs having the time, ability and motivation to ask women about IPV/FV during this period of higher risk is important given that women are more likely to disclose to someone they can build a trusting relationship with over time [17].

Interestingly, most comments from regional and rural GPs regarding barriers to discussion and disclosure of IPV/FV focused on patient-related factors. This suggests that most respondents felt patients were the main factor in whether or not a patient discloses experience of abuse. This contrasts with the wider literature on GP consultations from a patient perspective where patients often report GP-related barriers to disclosure. Multiple studies have shown that patients are more likely to disclose to a GP who is non-judgemental, non-directive, sensitive, a good listener and perceived as being confident and knowledgeable about IPV/FV, including relevant services [14, 18, 19]. Patients value repeated asking, follow-up and being given the opportunity to build a trusting relationship with their provider before disclosure [12, 14]. Other studies from patient perspectives also highlight the importance of repeated enquiry about the subject and that 'leaving the door open' for women is key in allowing them to know that help is available from their GP when they require it or are ready to disclose [11, 20]. GPs additionally need to have the motivation to ask and to feel that it is a legitimate part of their role to enquire about IPV/FV [38]. These are all aspects of GP-facilitated communication that could potentially be pursued in future local regional and rural IPV/FV training opportunities.

Several GPs also raised the issue of patients being reluctant to discuss the abuse once identified or to make decisions and changes. Health practitioners feeling that they need to solve the problem, as they often need to with physical health concerns, can act as a barrier to identification and management of IPV/FV [14]. For example, nurses who felt that victim/survivors would not leave their abusers have described ignoring signs of abuse and being reluctant to raise the issue [41]. Other health practitioners have voiced feelings of frustration and a sense of hopelessness when their efforts are not realised in a change by the patient experiencing abuse [29, 41]. Shifting GPs' understanding from feeling responsible to solve the situation to recognising their unique place in labelling IPV/FV, validating and assisting the patient would help with this issue. Validation is a critical step in the patient moving from the pre-contemplation to contemplation stages of change. Increasing GPs' ability to match interventions to readiness of change (given that only one third agreed that they could do this) and enhancing GP knowledge that patients can make appropriate choices for themselves (only one quarter agreed), may help to reduce GP frustration around 'patients not making change'. GP attitudes around patients being able to make appropriate choices is of broader importance as it may limit joint decision making and further reduce the power and control that patients have over their situation. Victim-survivors are often acutely aware of the increased risks they will face when leaving an abusive relationship, so improved understanding of this dynamic by health professionals may be an additional way to reduce feelings of frustration when their patients choose to stay with a perpetrator, by enabling them to be more compassionate and respectful of their patients' decisions. GP registrars were more likely than GPs to feel that individuals experiencing IPV/FV can make appropriate choices, suggesting that there could be a shifting paradigm in teaching in this area.

There were inherent contradictions in the survey and qualitative responses with respect to whether time was an issue for regional and rural GPs. In the Likert-scale questions, only 4% of GPs responded that they did not have time to ask about IPV/FV, however time was commonly reported as an issue in the open responses. GPs saw time, a lack of skills or training, and difficulties with establishing rapport and trust as frequent barriers. Reasons for this discrepancy are not clear but could relate to the fact that asking about IPV/FV is usually not a simple one-off question, rather it requires time to build therapeutic relationships with patients to enable initial disclosure as well as time to follow-up and provide counselling and social support once identified. Financial costs for patients to see GPs and the lack of appropriate time-based remuneration for GPs to see patients experiencing IPV/FV is problematic in the rural context, with fully funded GP consultations being less commonly available than in metropolitan areas. Regional and rural GPs are also often under additional time pressures because of shortages in the GP workforce. Systematic changes in the GP environment, for example, appropriate time-based Medicare item numbers and more automated prompting about relationships as part of preventive health screens, were recommended. Time is seemingly integrated in complex ways with other barriers and enablers of disclosure, rather than a factor that stands alone.

Without policies and training within broader systems, the decision to ask about IPV/FV, how health professionals respond to it and whether they feel it is within the scope of their role will reflect individual beliefs and experiences [41]. Bias or avoidance of the issue of IPV/FV could be unconscious so increasing knowledge and skills along with addressing systemic issues will assist with more effective change [41]. This requires more prioritisation of IPV/FV in budgets and policy development

Table 4 Potential interventions that would warrant further investigation for their effectiveness at improving IPV/FV recognition and management in the regional and rural primary care setting

Micro – Health Provider Level	Meso – Health Systems Level	Macro – Societal Level
Offer locally developed and run education to enhance GP knowledge of: • The role of the GP in facilitating GP-led disclosure of abuse • The importance of GPs identifying and validating patient concerns • Patient-centred and collaborative decision making • Local community IPV/FV referral and service information. .	Increase GP knowledge of local referral resources through: • Annual GP updates on IPV/FV service availability as part of awareness raising events (such a White Ribbon Day) • Improved centralised coordination, partnerships, referral pathways and joint care within local communities though enhancing relationships between services, including determining whether local advocate services could be better integrated into primary care.	Advocate for the availability of Medicare items for IPV/FV, as well as time-based items to enable closer follow-up, rapport and trust building with patients experiencing abuse.
Offer practical skills training sessions on: • Identification of patients experiencing violence • Developing safety plans • Brief interventions and matching interventions to the readiness of the patient • Assisting patients to make decisions about their future.	Automate GP prompting about relationships as part of preventive health screens.	

as, despite its high prevalence, the response to recognising IPV/FV in key policy documents as an underlying social driver of health concerns was slow [42]. However, there has been recent changes at a broader level such as the introduction of family violence leave and the 'Leaving Violence Program' financial assistance [43] from the Australian government, which indicates that positive change for victim/survivors is occurring.

The lack of a clear central coordination service for people experiencing IPV/FV, difficulty in accessing timely supports, not understanding the supports available following disclosure, and difficulties obtaining practical assistance were all identified barriers to assisting patients experiencing violence within this regional community. Similarly, healthcare providers from multiple studies that were not rural-specific have reported the barrier of a lack of effective interventions for IPV/FV if it is identified [30]. Being unable to help a patient who discloses experiences of abuse is a known barrier to enquiry, so ensuring adequate pathways for assistance is an essential element for increasing both recognition and management of abuse in general practice. The IRIS (Identification and Referral to Improve Safety) programme in the UK aimed to reduce GP barriers to identifying and responding to patients experiencing abuse. It included training and ongoing assistance for GP practices in IPV/FV identification, support and referral, and provided specialist advocacy support to referred patients through specially trained advocate-educators [11, 44–46]. This intervention significantly increased both rates of IPV/FV identification and referral to advocacy services. Similarly, Gear et al. (2016) looked at key enablers of developing a primary care response to IPV/FV [47]. They found that it was necessary to appoint a lead agency to coordinate, find and share information, build partnerships within the local community, build referral pathways and to organise education with specialists. Likewise, locally available IPV/FV partnerships, coordination, referral and joint care in this regional community seem to offer an important solution for the regional and rural GP respondents in this study. It is fortunate that an organisation advocating for and assisting women experiencing violence already exists in this community. However, there is a concern that such high-level coordination may not be possible in a rural area where health budgets and professional resourcing is already stretched.

Based upon the study findings, and associated findings in the literature, potential interventions for improving IPV/FV recognition and management in regional and rural areas at provider, health system and societal level are summarised in Table 4. These proposed approaches warrant further investigation as to their effectiveness for improving regional and rural primary care IPV/FV recognition, assistance and outcomes.

Continued research on programs to enhance primary care recognition and support for victim/survivors in regional and rural areas is required. Additionally, it is important to note that although this study has focused on GP perspectives, further information on patient experiences, barriers and enablers to IPV/FV disclosure and support in regional and rural areas would be valuable.

Limitations

Limitations to this study included the small number of GPs in practice in this region and hence the small numbers of respondents, despite a good response rate (43%) given the known challenges of engaging GPs in completing surveys, with time constraints in general practice being even more pervasive in rural practice. This limits statistical analysis and representativeness, particularly for subgroup analyses and has limited the ability to make comparisons. Response bias is also probable, whereby those GPs with an interest or more knowledge in this area of practice were more likely to participate. For this reason, the study is more likely to have over-estimated the education level and experiences of GPs in the space of IPV/FV rather than underestimated it.

Although the questionnaire items used in this study were based on a validated survey, it was edited from the original version for local appropriateness and to reduce respondent burden. Although the survey used a Likert scale with midline options, most respondents used the range of the scales. GPs were able to add free text responses to clarify their viewpoints. However, social desirability bias whereby practitioners responded as they thought they 'should' rather than reflecting on what they would do in a 'real life' scenario may have occurred.

Future studies to assess whether these findings are applicable and generalisable to other regional and rural areas in Australia are suggested. In particular, engaging GPs working more remotely may identify different issues that impact upon referral and access to specialist IPV/FV support and social services.

Conclusion

Several factors point to the need for further education and training for regional and rural GPs related to IPV/FV, particularly related to initial enquiry about IPV/FV, safety planning, appropriate local referral and pathways to support services. Findings from this study can inform future IPV/FV initiatives to improve the identification of victim/survivors and the support offered within regional and rural primary care settings. The findings also support the need for upstream changes to the funding of general practice to improve the ability of GPs to build relationships with patients over time and to allow more focus on IPV/FV, recognising the complexity of victim/survivors' lives which need to be adequately addressed before changes can be successfully made.

Abbreviations

FV	Family Violence
GP	General Practitioner
IPV	Intimate Partner Violence

Supplementary Information

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Supplementary Material 1

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Author contributions

CC contributed to the design of the study, instrument selection and design of the data collection tool, a review of the literature, data analysis and drafted and revised the manuscript. HG contributed to the initial conception and design of the study, instrument selection and design of the data collection tool, and analysis of the qualitative data. AG contributed to the initial conception and design of the study, design of the data collection tool, and applying the findings to the local context including assisting with the formation of recommendations. DP contributed a review of the literature, drafting of the manuscript introduction, data collection, data entry and data cleaning. LP contributed to the initial conception and design of the study, instrument selection and design of the data collection tool. SCT contributed to the initial conception and design of the study, instrument selection and design of the data collection tool, advised on analysis of the data, and completed substantial editing of the manuscript. All authors reviewed the manuscript.

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Data availability

Data is provided within the manuscript. The original datasets used and analysed during the current study are not publicly available due to the small number of General Practitioners in the region and the potential for identification of individual responses if the data set (which includes demographic details) is provided to the public. However, access to the original dataset may be made available on request through contact with the corresponding author.

Declarations

Ethics approval and consent to participate

This research project was approved by the Human Research Ethics Committee of the Human Ethics office at The University of Western Australia (UWA) (Project Number RA/4/20/5878). All approvals occurred under the principles set out in the National Statement on Ethical Conduct in Human Research (2007) (the National Statement), and the University's policies, terms of reference, and constitutions. Methods were carried out in accordance with the Declaration of Helsinki. Informed consent was obtained from all participants in the study. There were no financial or other incentives for the completion of this questionnaire.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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