Culturally competent and online: domestic violence and abuse training for primary healthcare practitioners

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In the spirit of reconciliation, we would like to acknowledge that we undertook this research on the lands of many Traditional Owners. We pay our respects to Elders past and present and to any First Nations people joining us today from anywhere in the world.
Rationale for HARMONY

- People from low-middle-income countries migrate to high-income countries.
- Melbourne, Australia has a large South Asian migrant and refugee community (ABS, 2016).
- Migrant women experiencing domestic violence are at an increased risk of serious harm or death (Vaughn et al, 2015).
- Australia’s primary healthcare capacity is enhanced by South-Asian family doctors (General Practitioners (GPs) in Australia.
- Unique intervention, cultural safety and domestic violence training for primary healthcare practitioners
Primary healthcare in Australia

- Funded through Australian federal national health insurance (Medicare)
  - primary healthcare is free (bulk-bills) or co-payment for patients.
  - Affordable and accessible
  - GPs see the whole family
- Most clinics are private businesses and receive rebates for patient attendance.
- GPs record patient visits on electronic medical software.
HARMONY is a pragmatic cluster RCT of culturally competent systems intervention to prevent and reduce domestic violence among migrant and refugee families in primary healthcare.

To be eligible, primary healthcare clinics had to have

- ≥1 South Asian bilingual/bicultural GP;
- use either of the two most common medical software programmes in Australia and;
- agree to have anonymised data extracted from their medical records.

HARMONY was significantly impacted by COVID-19.
HARMONY Aims & Objectives

HARMONY aimed to primarily increase:
- GP identification of domestic violence and;
- referral of domestic violence patients among all women aged 18+.

HARMONY’s secondary aim was to:
- Increase GP safety planning for domestic violence patients among women aged 18+.

HARMONY explored the rates of identification, referral and safety plan among the south-Asian women

(Taft et al, 2021)
Methods

• HARMONY recruited and randomised 24 clinics into intervention and comparison groups.
• Clinics from areas with a large south-Asian population.
• The training provided to the intervention clinics had a ‘whole-of-clinic’ approach.
Cultural competency, humility and safety

Cultural humility: Critical self-reflection
Cultural competence: Individual and systemic knowledge, attitude and skills
Cultural safety: Outcome

(Campinha-Bacote 2019; Cross et al. 1989; Curtis, Jones et al. 2019)
HARMONY Curriculum

❖ Session 1 (all staff)
  - Explore the challenges and opportunities for providing safety and care in cases of domestic violence among ethnically diverse community

❖ Session 2 (clinical staff only)
  - Enhance skills in listening and responding to patients who have experienced violence, particularly women from migrant and refugee backgrounds

❖ Session 3 (clinical staff only)
  - How to make a safety plan and refer to a cultural safe domestic violence service
Role of the Advocate Educator & Case Manager

- Co-train clinic staff with GP educator in identifying, safety planning and referrals.
- To support GPs and patients 12 months during covid-19.
- Host community of practice sessions to upskill GPs in culturally safe domestic violence care.
Strengths & weaknesses of training during COVID-19

❖ Strengths

• Flexible training sessions
• Zoom functionality
• Anonymity if distressed by any content
• Increase telehealth skills

❖ Weaknesses

• Technology issues/limitations
• Engagement of learners/ burnout
• Reduced fidelity of the simulated role-play
• Inability to monitor psychological well-being of learners
Conclusion

• Cultural safety and competency are essential in primary healthcare.

• Online training is complex.

• During COVID-19, an accessible online domestic violence training program is essential for GPs and other healthcare providers.
Thank you

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