



Australian
National
University



THE UNIVERSITY OF
MELBOURNE

Final Report: Promoting EARly intervention with men's use of violence in ReLationships through primary care (PEARL study)

Kelsey Hegarty¹, Laura Tarzia¹, Kirsty Forsdike-Young¹,
Rodney Vlasis², Michael Flood³, Gene Feder⁴, Cathy
Humphreys¹

¹The University of Melbourne; ²No to Violence; ³University of Wollongong; ⁴University of Bristol, U.K.

ACKNOWLEDGEMENTS

This research is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Australian Government Department of Health.

We wish to thank Macedon Ranges and North Western Melbourne Medicare Local, Nexus Primary Health, MonashLink Community Health Service and all our focus group and interview participants.

CITATION

Hegarty K, Tarzia L, Forsdike-Young K, Vlasis R, Flood M, Feder G, Humphreys C.
Final Report: Promoting EARly intervention with men's use of violence in
ReLationships through primary care (PEARL study) March 2016. APHCRI, Canberra

Department of General Practice

The University of Melbourne

VIC 3053 Australia

T 61 3 8344 4992

F 61 3 9347 6136

E k.hegarty@unimelb.edu.au

<http://www.unimelb.edu.au>

Contents

Background.....	4
Methods.....	6
Piloting a primary care intervention.....	6
Review of the literature.....	8
Focus groups with men.....	10
Interviews with GPs.....	11
Results.....	12
Piloting a primary care intervention.....	12
Evaluation.....	13
Review of the Literature.....	15
Focus groups with men.....	17
Interviews with GPs.....	18
Discussion.....	20
References.....	22

Background

In 2014 the Australian Primary Health Care Research Institute (APHCRI) sought applications for the 'Supporting research capacity building in primary health care program' 2014 APHCRI Foundation Grants. The provision of funding upholds the aim of APHCRI, which is to:

“support and develop primary health care research which is driven by the health care needs of the Australian community and can directly inform the development and implementation of health policies and services” (1)

Following receipt of an APHCRI grant, the Promoting EARly intervention with men's use of violence in ReLationships through primary care study (PEARL) sought to address current evidence gaps by developing and piloting a consumer-informed early intervention in primary care for men who use violence.

Domestic violence (DV) is a major social issue in Australia, (2) with an estimated annual cost of \$13.2 billion (3). DV is defined as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including aggression, sexual coercion, psychological abuse and controlling behaviours (4). It is primarily perpetrated against women by men, both in Australia (2) and globally. One in three women worldwide and one in five Australian women report physical or sexual abuse in a relationship by their male partners.(4) This is particularly alarming in light of the severe negative effects of DV on women's mental and physical health.(4, 5) There are also a range of negative outcomes associated with men's perpetration of DV, although literature on the subject is scarce.(6) These include increased alcohol and substance abuse, low self-esteem, increased rates of depression, stress and anxiety, and use of health services.(7, 8)

Although research into effective interventions for women experiencing DV has shown promising results,(9) it is becoming increasingly acknowledged in policy and practice that efforts to end violence against women must address male perpetrators.(10) Despite this, there is a lack of evidence for prevention models or early interventions in the DV area targeting men.(11) Limited evidence for prevention models comes from outside health care settings, mainly school based or educational campaigns.(12) A recent literature review (11) of the effectiveness of DV perpetrator intervention programs in the specialist sector shows mixed evidence but suggested the need to match programs to offender characteristics (e.g., risk, motivation, need), requiring initial screening processes and reliable and valid assessment tools.

The World Health Organization (WHO) has identified the crucial role of an effective primary care system in prevention of DV.(13) General practitioners (GPs) are well-placed to identify and respond to DV, since they are accessed regularly for a range of health issues. In particular, GPs are often the only clinicians seeing both women experiencing abuse and perpetrators, yet, there is very limited evidence to guide the practitioner response.(14) Currently in primary care, the majority of perpetrators are not even identified,(15) despite one study (16) reporting that 13.5% of male primary care patients had perpetrated minor violence over the past 12 months, and 4.2% reported severe violence. While it is unlikely that men will spontaneously disclose to a GP, they may present with mental or physical health problems, difficulties controlling their anger at times of acute crisis in their relationship, including during break up and separation, pregnancy and the postnatal period.(17)

It is essential that GPs are equipped to recognise the warning signs of perpetration and to respond appropriately, yet there is currently a major evidence gap for how to intervene early with male perpetrators in primary care. While services and support for victims continue to be essential, they need to be underpinned by intervention strategies which directly target DV perpetrators and assist them to stop offending.(18)

The PEARL study sought to address these gaps by developing a user-informed GP intervention to improve the identification and response to men who use violence against their partners.

The aim of the research was to develop an early intervention in primary care for men who use violence against their partners and to answer the following questions:

1. What evidence is there around effective interventions for men to identify and intervene early in DV?
2. What do men who use violence and GPs think would be an effective method of identification and early intervention in primary care, as well as the barriers and facilitators?
3. Can a GP intervention be feasibly implemented to identify and intervene early with men who use violence?

Methods

There were five phases to this intervention development,

1. pilot the feasibility of a primary care educational intervention in general practices
2. review the literature around interventions for male perpetrators in health care settings
3. conduct focus groups with men who have used violence against their partners to explore desirable and effective content for a GP intervention
4. conduct interviews with GPs to explore their perceptions of working with men who use violence against partners and what would best assist the GPs in their work
5. draw together the findings from phases 1-4 to develop a model for primary care in working with men who use violence in their relationships.

PILOTING A PRIMARY CARE INTERVENTION

We used CI Hegarty's WEAVE intervention (9) for women survivors of DV as a successful primary care intervention model. WEAVE screened women attending 55 general practices for fear of a partner in the past year and invited them for brief counselling by trained GPs. It showed a reduction in women's depressive symptoms and trained GPs more often inquired about safety.

We know at the undergraduate level, that medical students are given less than three hours of specific family violence learning throughout their course.(19) Similarly, although family violence is outlined in the curriculum for training for young doctors training to be GPs, in practice this is also often less than three hours. No training is provided in relation to working with men who use violence in their relationships.

Understanding this context, as a preliminary part of an intervention for men who use violence against their partners, we sought to pilot the feasibility of a training programme developed for and delivered to general practice in how to identify and respond to men who use such violence. Any primary intervention developed for men who use violence would require general practice to be able to identify and appropriately respond to their male patients.(20)

In developing the training programme, insights from behaviour change theory and practical steps for training from clinical and academic experience were used. Research has indicated that what works for health professionals includes: multi-faceted educational interventions,(21) effective training strategies,(22) practice visits & feedback by peers (physicians have been found to be better than non-physicians for this)(23). The training programme aligned with the Stages of Change theory (24-26), presenting a continuum along which a man may be positioned in terms of how ready he is to acknowledge and act upon his violence towards his partner. This feasibility pilot also drew upon Health professionals Responding to Men for Safety (HERMES), a study of an intervention delivered in the U.K.(20) The HERMES study sought to evaluate the feasibility of a training intervention for family practice to improve the response to male patients who had experienced or perpetrated DV. The intervention consisted of a two-hour interactive training session given by a GP and DV specialist to clinicians. Reception and administrative staff were also offered a one-hour information session on the intervention. Results of the study showed a significant increase in clinicians' self-reported preparedness to meet the needs of male patients experiencing or perpetrating DV abuse. Training also increased clinicians' confidence in responding to male patients.

The training programme sought to teach GPs to know when and how to identify men who use violence against their partners and how to respond. The training programme utilised multiple strategies, each enhanced by a strong evidence base in the training of health professionals: active listening exercises, attitudinal exercises and role plays.(27-30) The

programme also drew upon the Royal Australian College of General Practitioners' (RACGP) manual *Abuse and Violence: Working with our patients in general practice* 2014 4th edition (White Book) and the gplearning online Active Learning Module on Domestic Violence. The White Book is a manual for GPs and Aboriginal Health Workers and Practitioners in Australia on working with patients who have experienced or are currently experiencing abuse and violence. Those participating in the programme were requested to read parts of the manual as part of the distance-learning component.

The training programme formed several parts, as detailed below,

1. prior to teleconference and practice visit, each participant was asked to read specific chapters of the White Book and the training programme's participant handbook
2. each clinical participant was asked to undertake an audit of 10 consecutive male patients, the aim of which was for them to
 - a. self-reflect on their own consultations and reflect on the strengths and areas requiring improvement
 - b. analyze psychological issues underlying presentations (including DV)
 - c. identify the reasons why certain consultations prove to be difficult and what can be altered to reduce the degree of difficulty
3. each participant was asked to review a practice checklist to reflect upon what their practice already does in terms of its readiness to respond to patients experiencing DV and what further could be developed to improve such response
4. attendance at a teleconference to discuss the safety of women and children
5. attendance at the one-hour practice visit for all general practice staff to,
 - a. explore the challenges and opportunities for providing care in cases of DV
 - b. reflect on the barriers and facilitators to responding to men who use violence in their relationships
 - c. discuss how the practice may improve responses to men, women and children experiencing family violence
 - d. consider how change within the practice can be sustained, and
6. completion of pre- and post- surveys/evaluation forms to enable participants to reflect on their own attitudes which might facilitate or inhibit an effective response to men who have experienced violence; and to self-reflect on participating in the training program.

Recruitment of general practices to pilot the training programme was undertaken in collaboration with the former Macedon Ranges and North Western Melbourne Medicare Local, who provided additional funding support to develop and deliver the training to multiple practices in the Macedon Ranges and North Western Melbourne region. Following this pilot, the team, in collaboration with men's behaviour change programme experts, co-authored a paper that was published in the *Australian Family Physician* in April 2016.(31)

REVIEW OF THE LITERATURE

We undertook a systematic review of the literature to identify effective interventions for male perpetrators of DV in health care settings.

The review question was: What interventions are effective at improving outcomes for male perpetrators or victims of domestic violence in health settings?

The electronic databases Medline, CinAHL, PsychInfo, EMBASE and Cochrane Library were searched for relevant published and unpublished studies in any language using the search strategy in Table 1. Further electronic resources were also searched, including the World Health Organisation website (<http://whol.int/topics/violence/en/>), intimate partner violence-specific online resources, including the Violence Against Women Online Resources website (<http://www.vaw.umn.edu/>), the New Zealand Family Violence Clearinghouse, and the Domestic Violence Data Source (www.lho.org.au/viewResource.aspx?id=9443) were also searched.

Table 1 Systematic review search strategy

Medline, PsychInfo, EMBASE and Cochrane Library		CinAHL
1	Men OR male OR man.ab,tw	AB (male or men or man) AND AB (family violence or domestic violence or partner violence) OR AB spousal abuse OR AB dating violence AND AB (intervention or treatment or counselling or program or screening) AND AB (hospitals or clinic or antenatal or dental or general practice or primary or emergency or doctor or nurse or alcohol treatment or mental health) NOT AB (jail or gaol or prison or school)
2	Domestic violence.ab,tw	
3	Spousal abuse.ab,tw	
4	Dating violence.ab,tw	
5	Partner violence.ab,tw	
6	Family violence.ab,tw	
7	((abus* or batter* or violen* or beat*) adj3 (domestic or partner* or family or families or spouse or marital or woman or women or man or men or female or male or wife or wives or husband or boyfriend or girlfriend)).ab,tw.	
8	(Intervention or treatment or counselling or program or screening).tw,ab not (jail or gaol or prison or school)	
9	1 AND (2 or 3 or 4 or 5 or 6 or 7)	
10	(hospital or clinic or general practice or ED or emergency or doctor or nurse or surgeon or primary or dental or antenatal or outpatient or "alcohol treatment" or "mental health" or "substance abuse treatment").ab,tw.	
11	8 AND 9 AND 10	

The target search population was men aged 16 years and over who have perpetrated or been victims of DV. Victims of child sexual abuse were excluded. The interventions searched for included any type of intervention that was recruited in the community or a health setting and then conducted in a health setting, and addressing male perpetrators or victims of DV. Health settings included general practice, clinic, hospital, health centre etc. and interventions in community, legal, justice, or other settings were excluded. The

interventions needed to have a clear pre/post evaluative component in order to be able to assess effectiveness. The types of study included were: systematic reviews, meta-analyses, randomized controlled trials (RCTs), case-control studies, cohort studies, qualitative studies (providing there was a pre/post evaluation component). Other study types were included if there was a pre/post evaluation component. Excluded study types were: narrative reviews, letters, editorials, commentaries, case reports, conference proceedings, meeting abstracts, lectures and addresses, and consensus development statements (including guideline statements); any study that did not have a pre/post evaluation component.

The primary outcomes of interest were: reduction in violence, improved mental health outcomes for victims or perpetrators, reduction in number of intervention orders or police reports over any period. Secondary outcomes of interest were: increased identification of victims or perpetrators, increased referral of victims or perpetrators, increased self-efficacy in victims or perpetrators, reduction in alcohol or substance abuse by victims or perpetrators, again over any period.

Two reviewers read the titles and abstracts of citations retrieved from searching the electronic databases, and rejected those that did not meet the inclusion criteria. The same two reviewers read the full text of the remaining articles and confirmed eligibility. In the event of any uncertainty, a third reviewer was consulted. Data from eligible studies was extracted, including study design, sample characteristics, type of intervention, and outcomes.

All eligible papers were independently reviewed by two reviewers using the Critical Appraisal Skills Program (CASP) checklist. The reviewers compared reviews, and consulted a third reviewer where disagreements arose.

Because the review included many different types of study, and because we were reporting on a variety of outcomes that could determine “effectiveness”, we did not use statistical analysis to report the findings. It was also anticipated that very few RCTs or rigorous quantitative studies would be found. Consequently, data is reported using narrative synthesis, highlighting the characteristics of interventions that promote or impede effectiveness.

FOCUS GROUPS WITH MEN

Men who had used violence in their relationships and who were attending a men's behaviour change programme were invited to participate in a focus group. The aim of the focus groups were to discuss how men may seek help for an unhealthy relationship and how they can be encouraged to seek help earlier. More specifically, we wanted to explore men's perceptions of the most effective ways GPs can talk and respond to male patients who may be using violence in their relationships, and what is needed to motivate them to seek help.

We recruited through two men's behaviour change groups, one rurally based and one metropolitan. The focus groups were facilitated by a member of the research team and attended by a second member of the research team as note-taker as well as the usual men's behaviour change group facilitator.

The topics that the focus group facilitator covered were,

- > the ways men seek help when they are in an unhealthy relationship
- > men's thoughts on their GP asking them about their relationship
- > best ways for GPs to raise the topic
- > what they want from their GPs in terms of support
- > how technology may encourage men to seek help

Focus group discussions were recorded, transcribed, coded and thematically analysed using Nvivo.

INTERVIEWS WITH GPs

We sought to undertake interviews with GPs to explore their experiences of working with male patients who may be using violence in their relationships.

GPs were recruited from amongst those general practices to which the project team had a connection, with some having attended the training delivered as part of the 'piloting an intervention' phase.

Topics covered during the interviews included,

- > identification and response to male patients who may be using violence
- > the role of GPs in responding to men who use violence
- > how GPs should initially raise the topic with male patients
- > GPs and their patients' experiences with services for men who use violence
- > the use of technology as part of a response

Interviews were expected to take around 30 minutes during work hours. GPs were offered either a face-to-face interview whereby the researcher would attend the clinic, or via telephone.

Interviews were recorded, transcribed, coded and thematically analysed using Nvivo.

Results

The multi-disciplinary research team successfully drew upon existing experience, consumers and stakeholders in the delivery of this project. Stakeholders included 'No to Violence' (NTV), Nexus Primary Health, Macedon Ranges and North Western Melbourne Medicare Local (MRNWMML) and MonashLink Community Health Service.

Each of the four components of the study were analysed individually and then drawn together to develop a model of care for working in primary care with men who use violence in their relationships.

PILOTING A PRIMARY CARE INTERVENTION

Six general practices were recruited to pilot the training programme, including a total of 67 general practice staff. See Table 2 below for details.

Table 2: Pilot training programme participants

	GPs	Practice Managers	Nurses	Receptionists/ Administrators	Med. Student	Allied Health
Practice 1	9	1	4	0	1	1
Practice 2	12	1	1	0	0	0
Practice 3	3	0	2	0	0	0
Practice 4	2	1	2	1	0	0
Practice 5	3	0	1	2	0	0
Practice 6	7	0	5	8	0	0
Total	36	3	15	11	1	1

Of the 67 staff trained, 25 pre-training surveys were received from participants. The majority of responding participants were female (84%), and the average age was 41 years (range 19 to 50+ years of age). Most practice staff had received less than one hour of training in family violence (60%, n=15) with three receiving over 11 hours of training (one being a nurse and two being GPs).

Of the 16 clinician respondents (GPs and nurses), approximately half had not asked men about past sexual abuse or intimate partner abuse within the last three months. However, over 80% said they had been comfortable or very comfortable asking about anxiety, relationship problems, depression, social isolation and drug and alcohol use.

Interestingly, 13 responding participants either did not think patient education or resource materials were available at their practice whilst 10 had said they were available (although not necessarily accessed or well displayed). Training may enable participants to work together as a practice to understand and collectively know what is available to patients within the practice to ensure consistency of knowledge and understanding of the practice response to DV.

Responding participants indicated that they may find the following challenging when undertaking the program,

- > asking about sexual abuse or sexual assault within families
- > self-reflecting on personal experiences of abuse or finding out about violence affecting staff

- > increased awareness highlighting situations where family violence was previously overlooked
- > discussing violent behaviour with a perpetrator and how to start the conversation
- > building sufficient rapport with patients for them to talk about abuse.

Responding participants hoped to gain the following from the Programme,

- > understanding and knowledge of DV
- > improved skills in interviewing and assisting patients, effectively and sensitively
- > improved recognition or awareness
- > improved identification of risks for patients
- > find help for the patient
- > better understanding and confidence in working with patients
- > resources.

Evaluation

Participants were asked to complete an evaluation of the training programme upon completion of the practice visit. Of the 67 participants, 28 (42%) provided completed evaluation forms.

Almost all participants (96-100%, n=26-28) rated their needs as completely or partially met, with all participants responding that they felt the training programme was entirely relevant to their practice. Needs were broken down into the following sections,

- > improved communication skills
- > increased confidence in identifying men who use violence in relationships
- > improved ability to refer men to appropriate services
- > ability to reflect on own attitudes
- > developed skills to assess safety of women and children
- > enabled access to up to date evidence regarding abuse
- > overall degree to which learning needs were met.

The overall quality of the training programme was considered good or excellent by 71% of responding participants (n=20) with 68% (n=19) finding the appropriateness of length and material covered in the training programme was good or excellent. However, one participant commented that the practice visit aspect of the training programme could be longer and run over several weeks to achieve its full benefit.

The responding participants particularly valued the opportunity to ask questions and to interact during the training programme, with 93% rating this as good or excellent (n=26).

However, resources provided as part of the programme were not necessarily used by the participants. Despite an intrinsic part of the programme and being free and easy to access for all general practice staff, ten participants did not use the White Book. Positively, 96% (n=26) of responding participants found the Participant Handbook useful.

The practice visit and interactive aspects of the training programme were found to be the most useful to participants with information on local referral options being particularly important to them in providing appropriate care. All responding participants who answered the question (n=18), found that the training programme had increased their confidence in working with men who use violence in their relationships. This increase in confidence was reflected in their responses to what changes they may make going forward in terms of providing care. Responding participants indicated that they would endeavour not to be afraid to ask about DV, be more alert to it and to make use of the different services available to assist patients. Table 3 below lists the key responses from the open text questions from the evaluation.

Table 3 Evaluation qualitative responses

Question	Response
What did you find most useful?	<ul style="list-style-type: none"> > Practice visit > Learning how to identify and ways to approach the subject with a patient > Role-play of a conversation with a male patient > Group discussion > Information on available services and referral options > Managing confidentiality if seeing more than one involved party
What did you find most challenging?	<ul style="list-style-type: none"> > My own attitudes towards men who use violence in their domestic relationships > Learning that our 'instinctive response' might be the wrong one > Raising the topic of DV and trying to retrieve information from the patient > The complexities of continuing a conversation with a man who had disclosed use of violence whilst also not colluding with him
Describe any changes you might make to the way you provide care	<ul style="list-style-type: none"> > Ensuring it remains a front-of-mind issue for the practice and providing suitable resources for the waiting/consult rooms > Being more alert to the signs of DV amongst patients > Remembering to ask and not being afraid to ask > Will use different questions when identifying and responding to DV > Will make use of appropriate referral pathways, including support groups and crisis helplines > Be more mindful of caring for the family as a whole

REVIEW OF THE LITERATURE

From an initial 3,371 papers found using the search strategy detailed above, 13 papers were included in our review.

The main difficulty was establishing whether the study had been recruited/conducted in a health setting. The two main reviewers and the third reviewer met over three occasions to discuss several papers and establish whether the paper should be included in the review. For example, for one study it was agreed one reviewer would contact the author in order to establish the setting for the study as a health setting (subsequently confirmed).

There were very few studies found and as expected, a range of different types of study with greatly varying outcome measures meant only a narrative review could be undertaken. The study team will publish the results of the systematic review in full, but a summary of the review's findings is presented here.

Settings for the interventions with men who use or are victims of violence included: emergency departments, hospital or outpatient clinics, alcohol or substance abuse facilities, community mental health centres and general practice. In five studies, the primary target population was alcohol dependent men.(32-36) Of these five, three sought participants who had current partners.(34-36) Another three studies, with non-alcohol dependent men, also recruited men as part of a couple/who were seeking treatment for abusing their partner (including one focused on men who had served in the military).(37-39) The remaining studies recruited emergency department patients,(40-42) users and clinicians of a mental health service (43) and general practice clinicians.(44) Sample sizes for each of the studies were wide ranging, from 6 in one study (with their partners)(39) to over 300 for a study looking at heterosexual couples in which the man is alcohol dependent.(34) The majority studies (n=7) had under 50 men participating.(33, 35-39, 43) These are very low sample sizes and obviously would affect the quality of any results.

The types of intervention and how they were delivered varied widely. However, they mostly covered three broad themes,

- > some version of psychological therapy
- > provision of information, resources or training
- > prescription of the selective serotonin reuptake inhibitor, fluoxetine.

Five of the papers reviewed reported no comparator to the reported intervention.(36, 39, 41, 43, 44) Those that had a comparator, mostly it was placebo (in the case of a drug intervention) or usual care or simple information/list of resources only.

Outcomes measured also varied widely and a vast array of different measures or scales were used across the studies. Table 4 shows the different types of outcomes measured alongside the range of measures used. Qualitative interviews were also used in three of studies.

Table 4 Outcomes measured and scales/measures used

Outcome	Measures
Psychiatric measures (depression, anxiety, PTSD) Quality of life Substance use Violence and conflict (frequency and types) Changes in knowledge, behaviour and attitudes (for both patients and clinicians) Irritability, anger, aggression Functional health (psychological mostly) Safety Resources used 911 calls Relationships satisfaction Disclosure Documentation by health professionals	Addiction Severity Index (ASI) Conflict Tactic Scale (in various forms) Short Perpetrator RaPid Scale MOAS (modified overt aggression scale) Spielberger State Anxiety Inventory Hamilton Depression Rating Scale Partner Abuse Scale Universal Violence Prevention Screening Protocol Women’s Evidence of Battering scale Short-Form 12 (functional health status) DAS 32-item measure Quality of Marriage Index State Trait Anger Expression Inventory University of Rhode Island Change Assessment Structured Clinical Interview for DSM-IV PTSD Scale Physician Readiness to Manage DV Scale (PREMIS) Composite Abuse Scale (CAS) Manchester Short Assessment of Quality of Life Camberwell Assessment of Need for Mothers (short version)

With such varying intervention types, settings, outcomes and measures used, as well as questionable quality across the studies, comparison between the findings of each study was impossible.

From a procedural point of view, one key overall finding is that interventions can be recruited for and undertaken in a health setting for this population – whether it be psychological therapy, drug therapy, screening or referring. The key interventions that seemed to show some success included

- > a behavioural couples therapy programme for couples where the man was alcohol dependent significantly reduced the violence (also greater treatment involvement related to lower violence after therapy, mediated by reduced problem drinking and enhanced relationship functioning) (34)
- > a pilot randomised controlled trial of a brief motivational interviewing intervention for intimate partner violence (IPV) in addition to the provision of information and list of resources was found to be better than provision of information and resources alone in increasing help-seeking and improvements in motivation and intimacy (however, the study struggled with retention and being a pilot, had very small numbers of participants) (35)

- > an abstinence-oriented program that focused on substance abuse as a maladaptive behaviour pattern and also gave either cognitive-behavioural therapy (CBT) for depression or relaxation training found decreased alcohol use and significant decrease in husband to wife IPV (female partners reported a significant increase in marital satisfaction whereas men did not) (36)
- > a general practice study providing two-hour practice-based training program found significant increase in clinicians' self-reported preparedness to meet the needs of male patients experiencing or perpetrating DV (however, there was only a small increase in male patients identified within the medical records and only five of those patients contacted a specialist DV agency) (44)

FOCUS GROUPS WITH MEN

Three focus groups were held with 23 men across two men's behaviour change programmes in May, July and September. Ages of the participants ranged from 22 to 54 years, with the average age being 41 years. Some of the men had self-referred, many had been directed to attend by their partners or by the courts.

The participating men had varying perceptions of their relationships with their GPs. Some of the male participants did go to their GPs to seek help, with one explaining he had a good relationship with his 'family doctor' which made it easy for him to trust his GP. Issues with disclosing to GPs about their relationships and use of violence, where they were expressed, centred around the GP-patient relationship. Similarly to what research has found women want from their GP, men want GPs to have time to engage and listen – a walk-in clinic cannot offer this kind of support in comparison to a family clinic. One male participant highlighted that having a consistent or regular GP enables them to be able to detect red flags in their patient, identify stressors, tensions and conflicts and experiences that their patient may have and as such, they are able to build a rapport before asking more direct questions. However, it was openly acknowledged that not all men would have good relationships with their GPs, or be receptive to their GP raising such a topic. Furthermore, there may be many men who do not need to see their GP, who are considered fit and healthy and as such general practice would not be an appropriate avenue for engagement.

A key part of engaging men was using language that did not shut down the discussion. The male participants highlighted the lack of awareness many of them had in terms of their behaviour being 'violent' so use of that term did not engage them. They suggested using a language strategy similar to depression scales, where an overt label was not initially used.

Similarly, the term 'violence' was acknowledged as not necessarily capturing in men's minds all the ways in which abuse occurs. Violence, they raised, was predominantly seen as physical. Education is required to change this perception, and that violence can be psychological and emotional. The male participants considered the need in one focus group to spend less time focusing on the more extreme forms of violence – for example always displaying murder statistics. The men were keen to explain how best to phrase questions to engage men and get them thinking about their behaviour, for example,

- > How many times have you yelled?
- > Do you think your actions hurt those around you?
- > How does your partner/child see you?

One focus group raised how these sorts of questions could be asked by GPs as part of the forms often used in general practice.

With regards to intervention format, there were mixed reactions to the use of technology. Some men highlighted accessibility issues – not all of them had smart phones and older men may be excluded. However, most thought it could be a useful means to engage men more broadly as long as it was appropriately targeted to men and used language that would

engage rather than immediately blame. It was also seen as a stepping stone to raise awareness, engage men to reflect on their behaviour so that they could then seek more substantial support, for example through men's behaviour change programmes.

INTERVIEWS WITH GPs

We interviewed 12 GPs. As GPs are notoriously busy, interviews took place during a time convenient to them. This meant most interviews were conducted during the GP's working day and as such needed to be completed either during their lunch break or between consultations. Two GPs provided their personal telephone numbers to be contacted out of work hours. Interviews took place either over the telephone or face-to-face at the GP's clinic and lasted between 20 and 45 minutes.

The 12 GP participants came from six different general practices across both metropolitan and rural locations. Table 5 provides a summary of the participants.

Table 5 GP Participants

	No. of GPs
Male	5
Female	7
Rural Practice	5
Metropolitan Practice	7
Interview Face to Face	6
Interview via Telephone	6
Attended pilot intervention training	3

The full results of interviews with GPs will be presented in a peer-reviewed paper to be submitted for publication shortly.

A summary of the results are presented here.

Four key themes arose throughout the interviews. The first was that men who use violence in their relationships are hidden patients within the general practice population. Few of the GPs interviewed saw any men who they believed had either disclosed or were likely to use violence. The overwhelming belief was that these men did not attend their practice or at least would not disclose, often related to the idea that men often do not visit their GP unless for a prescription.

Issues around identification appeared to arise from the fact that GPs believed only men who openly disclosed or who appeared overtly aggressive during consultations would be those who used violence. Many of the GPs openly talked about the work they did with their male patients around mental health and drug and alcohol but these situations did not necessarily alert to the potential for violence in the men's relationships. Furthermore, almost all of the GP participants believed it was women who they saw more, who would be more willing to talk about these issues.

Some of the GPs were aware that their patient population would consist of some men who use violence but they had not 'identified' any specifically and a couple of the GPs were openly alert to the potential and actively asked and worked with their male patients on this topic – however, these GPs had extensive backgrounds of working with populations in which violence was more overt.

Despite men who use violence being a 'hidden' patient population, most of the GPs believed they had a role to play. However, this role was not always clear. Some appeared to believe their role was purely that of a care coordinator and to refer to the appropriate services such as mental health or drug and alcohol (very few knew of men's behaviour change programmes or other domestic violence services). Anything more than identify and refer was approached with caution, particularly with general practice issues around availability of time to manage such complex cases, potential fear of a violent patient and challenges relating to working with the whole family (with some of the participating GPs not aware of the guidelines for GPs not to counsel both parties in cases of domestic violence).

Uncertainty over their role highlighted perceived challenges faced by these GPs in engaging their patients in this topic. The key issue was how to raise the topic with male patients. Most of the GPs acknowledged this should be done in a non-judgmental way but some were also concerned with how to achieve this without 'colluding' with their patient. Two of the more experienced GPs suggested just asking, being up front about it and they, together with other GP participants, expressed the need to show their male patients that they were concerned for their health. Ways of engaging included making questions around relationships a part of their normal history taking and asking the question whenever issues around mental health or drugs and alcohol were discussed. However, it was clear GPs wanted specific, practical advice on how to ask and the words to use.

Beyond the initial disclosure, the GP participants alerted to the fact that referrals were often only made to those services or individuals working at the GP's clinic or who were known to them or their partners (two participants had partners who worked in this area) directly. Again, mental health and drug and alcohol services were the preferred options with domestic violence services and men's behaviour change programmes relatively unknown. Many of the GPs expressed a need to be better acquainted with the services in their area.

One strategy to engage with male patients that the GP participants were positive about was the use of technology, particularly in the form of a GP-patient collaborative tool. Many of the GPs already had experience of using online applications with their patients, predominantly around mental health (e.g. BlackDog Institute). There were a couple of GPs who preferred face to face engagement, although these GPs often had more extensive experience in this area, and one GP thought whilst it could be useful, its success would depend on the commitment of the male patient. Despite these potential issues, almost all GPs felt such an intervention had potential. The requirements of such an intervention, from the perception of the GP participants, would be that it was appropriately developed with extensive input from experts in the field, that it was evidence based, used appropriate language and was locally relevant. In particular, that such a tool was developed by a respected organisation that GPs could trust to deliver care to their patients that would help rather than hinder them, and used language that would be consistent across services that may be used to support men using domestic violence, including GPs and psychologists.

Discussion

It is clear that both men who use violence and GPs believe an intervention through primary care is feasible and has the potential to help identify men who use violence and get them to the support they need to address their use of violence.

However, any intervention should include sustainable training of GPs on this topic more broadly and specifically: how to identify male patients who may be using violence; and how to respond appropriately to them. Both the GP participants and men during the focus groups alerted to the doctor-patient relationship and the need for improved communication – both in terms of providing GPs with the confidence to raise the topic and for their male patients to feel supported and to trust their GP enough to disclose.

A technological intervention that can be used by both GPs and male patients collaboratively and individually may overcome some of the challenges raised by both the GP and male participants to the PEARL study. For example, it provides a practical means for GPs to engage with their male patients as well as supplementing their training in this area, assisting in the GP-patient relationship and linking with local services (that could be searched for via the intervention). It would also have the flexibility for men to use the intervention with or without their GP, opening it up to a broader population group including those who do not attend general practice.

PEARL also highlighted some key areas of technological intervention development that could be resolved as follows,

- > The intervention should be developed by a trusted organisation and with extensive input from experts working in this field to ensure it is seen as being of sufficient quality, is evidence based and will practically, either individually or in conjunction with their GP, engage and support men who use violence.
- > Significant marketing is required to ensure uptake by both GPs and their male patients, and ongoing training with GPs to ensure appropriate and collaborative use of the tool
- > Any intervention needs to be enhanced by training GPs to identify and engage with their male patients as well as training them how to use a technological intervention to best support their patient.

Following the results from our pilot intervention, review of the existing evidence, discussions with men and GPs, we have developed a model for working with men who use violence through primary care.

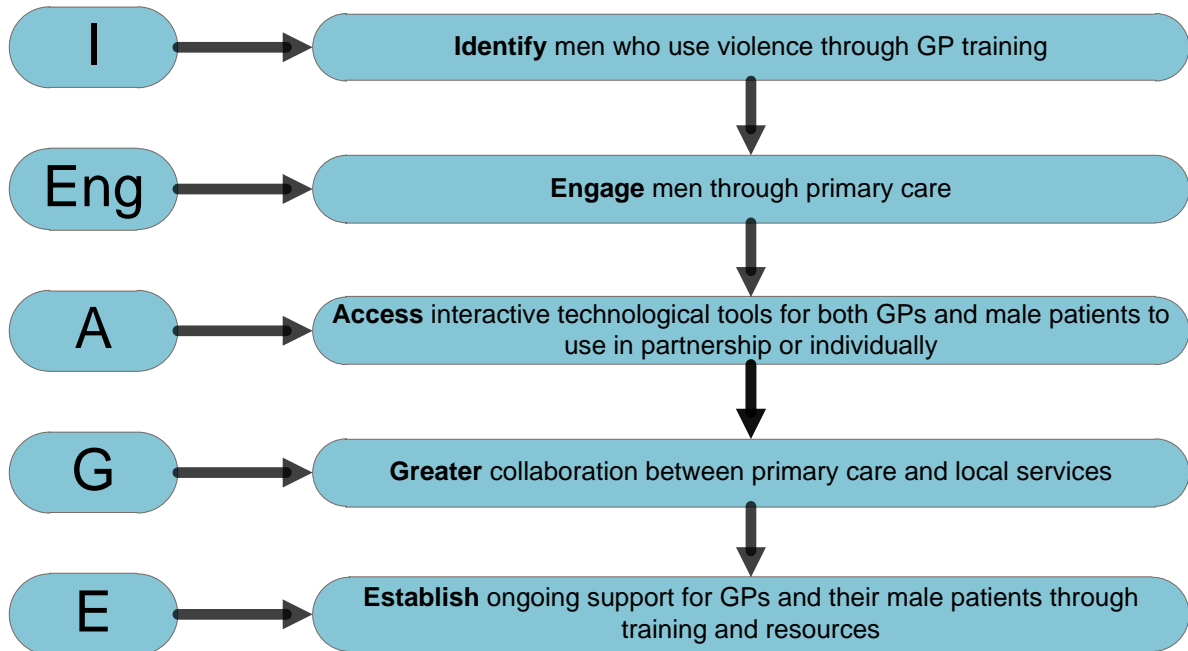
The model is called **I-ENGAGE** and draws on three key findings from PEARL,

1. GPs require training to support them to feel confident to identify and engage with their male patients who may be using violence, and such training needs to be ongoing
2. An intervention for men who use violence can be delivered through primary care but must include collaboration between general practice and local services to ensure appropriate and trusted referral pathways
3. An interactive tool is welcomed by both GPs and men, that can be flexible to be engaged with in partnership or individually depending on the circumstances

The key components of the **I-ENGAGE** model is as follows,

- > **Identify** men who use violence through GP training
- > **Engage** men through primary care
- > **Access** interactive technological tools for both GPs and male patients to use in partnership or individually
- > **Greater** collaboration between primary care and local services
- > **Establish** ongoing support for GPs and their male patients through training and resources

I-ENGAGE: a model for engaging men who use violence through primary care



It is envisaged that to undertake this model, an online and mobile application will need to be developed with extensive expert and consumer input and trialled. This would need to be combined with rolling out further continuing professional development for GPs and engagement with men through primary care as well as the public more broadly. Establishment of ongoing support would be achieved through ongoing and sustained training for GPs as well as collaboration with local services.

Conclusion

In conclusion, we found that a GP educational intervention can feasibly be implemented to identify and intervene early with men who use violence in their relationships. The project produced a substantial collection of information in the development of the model described above and will hopefully result in a number of peer-reviewed publications to increase dissemination of the results.

Through an extensive search of existing literature, focus groups with men who have used violence and interviews with GPs, we have developed a complex model that incorporates the facilitators whilst managing the challenges of implementing an intervention through primary care and working with men in this sensitive area. This model needs to be tested in an Randomised Controlled Trial. We are currently seeking partners in order to apply for an National Health and Medical Research Council Partnership Grant later this year.

References

1. Australian Primary Health Care Research Institute. 2016. Available from: <http://aphcri.anu.edu.au/>.
2. Australian Bureau of Statistics. Personal Safety Survey. In: Australian Bureau of Statistics, editor. Canberra 2012.
3. National Council to Reduce Violence Against Women and their Children. The cost of violence against women and their children. Canberra, Australia: Dept of Fam, Housing, Comm Serv & Indig Affairs; 2009.
4. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: WHO, 2013.
5. Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, et al. Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *JAMA*. 2011;306(5):513-21.
6. Oram S, Trevillion K, Khalifeh H, Feder G, Howard LM. Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence. *Epi & Psych Sci*. 2013.
7. Gerlock A. Health impact of domestic violence. *Issues in Mental Health Nursing*. 1999;20(4):373-85.
8. Coben JH, Friedman DI. Health care use by perpetrators of domestic violence. *J of Emerg Med*. 2002;22(3):313-7.
9. Hegarty K, O'Doherty L, Taft A, Chondros P, Brown S, Valpied J, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. *The Lancet*. 2013;382(9888):249-58.
10. Council of Australian Governments. National Plan to Reduce Violence against Women and their Children 2010-2022. Canberra: Australian Government; 2010.
11. Grealy C, Wallace A. Literature Review on Domestic Violence Perpetrators. Urbis Pty Ltd; 2013.
12. VicHealth. Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria. Melbourne: VicHealth, 2007.
13. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: WHO; 2013.
14. Royal Australian College of General Practitioners. Abuse and Violence: Working with our patients in general practice. 4th edition ed. Melbourne: Royal Australian College of General Practitioners; 2014.
15. Sugg NK, Thompson RS, Thompson DC, Maiuro R, Rivara F. Domestic violence and primary care. Attitudes, practices, and beliefs. *Archives of Family Medicine*. 1999;8(4):301-6.
16. Oriel K, Fleming M. Screening men for partner violence in a primary care setting. A new strategy for detecting domestic violence. *Journal of Family Pract*. 1998;46(6):493-8.
17. Taft A, Broom D, Legge D. General practitioner management of intimate partner abuse and the whole family: qualitative study. *BMJ*. 2004;328(7440):618.
18. Hester M, Westmarland N, Gangoli G, Wilkinson M, O'Kelly C, Kent A, et al. Domestic Violence Perpetrators: Identifying Needs to Inform Early Intervention. Bristol: The University of Bristol in association with the Northern Rock Foundation and the Home Office, 2006.
19. Valpied J, Aprico K, Clewett J, Hegarty K. Are future doctors taught to respond to intimate partner violence? A study of Australian medical schools. *Journal of Interpersonal Violence*. 2015:1-14.
20. Williamson E, Jones SK, Ferrari G, Debonnaire T, G F, Hester M. Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or

- perpetrated domestic violence and abuse. *Primary Health Care Research & Development*. 2014.
21. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. *JAMA*. 1995;274(9):700-5.
 22. Grimshaw JM, Shirran L, Thomas R, Mowatt G, Fraser C, Bero L, et al. Changing Provider Behavior: An Overview of Systematic Reviews of Interventions. *Medical Care*. 2001;39(8):II2-II45.
 23. Van den Hombergh P, Grol R, van den Hoogen H, van den Bosch W. Practice visits as a tool in quality improvement: acceptance and feasibility. *Quality in Health Care : QHC*. 1999;8(3):167-71.
 24. Burke JG, Mahoney P, Gielen A, McDonnell KA, O'Campo P. Defining appropriate stages of change for intimate partner violence survivors. *Violence Vict*. 2009;24(1):36-51.
 25. Alexander PC, Tracy A, Radek M, Koverola C. Predicting stages of change in battered women. *J Interpers Violence*. 2009;24(10):1652-72.
 26. Burkitt KH, Larkin GL. The transtheoretical model in intimate partner violence victimization: stage changes over time. *Violence Vict*. 2008;23(4):411-31.
 27. Gunn J, Hegarty K, Nagle C, Forster D, Brown S, Lumley J. Putting woman-centered care into practice: a new (ANew) approach to psychosocial risk assessment during pregnancy. *Birth*. 2006;33(1):46-55.
 28. Warshaw C. Educating health professionals: changing attitudes and overcoming barriers. In: Roberts G, Hegarty K, Feder G, editors. *Intimate partner abuse and health professionals: New approaches to domestic violence*. London: Elsevier; 2006.
 29. Frasier PY, Slatt L, Kowlowitz V, Glowa PT. Using the stages of change model to counsel victims of intimate partner violence. *Patient Educ Couns*. 2001;43(2):211-7.
 30. Gunn J, Southern D, Chondros P, Thomson P, Robertson K. Guidelines for assessing postnatal problems: introducing evidence-based guidelines in Australian general practice. *Family Practice*. 2003;20(4):382-9.
 31. Hegarty K, Forsdike-Young K, Tarzia L, Schweitzer R, Vlasis R. Identifying and responding to men who use violence in their intimate relationships. *Australian Family Physician*. 2016;45(4):176-81.
 32. Easton CJ, Mandel DL, Hunkele KA, Nich C, Rounsaville BJ, Carroll KM. A cognitive behavioral therapy for alcohol-dependent domestic violence offenders: an integrated substance abuse-domestic violence treatment approach (SADV). *American Journal on Addictions*. 2007;16(1):24-31.
 33. George DT, Phillips MJ, Lifshitz M, Lionetti TA, Spero DE, Ghassemzadeh N, et al. Fluoxetine treatment of alcoholic perpetrators of domestic violence: a 12-week, double-blind, randomized, placebo-controlled intervention study. *Journal of Clinical Psychiatry*. 2011;72(1):60-5.
 34. O'Farrell TJ, Murphy CM, Stephan SH, Fals-Stewart W, Murphy M. Partner Violence Before and After Couples-Based Alcoholism Treatment for Male Alcoholic Patients: The Role of Treatment Involvement and Abstinence. *J Consult & Clin Psych*. 2004;72(2):202-17.
 35. Schumacher JA, Coffey SF, Stasiewicz PR, Murphy CM, Leonard KE, Fals-Stewart W. Development of a brief motivational enhancement intervention for intimate partner violence in alcohol treatment settings. *Journal of Aggression, Maltreatment and Trauma*. 2011;20(2):103-27.
 36. Stuart GL, Ramsey SE, Moore TM, Kahler CW, Farrell LE, Recupero PR, et al. Reductions in marital violence following treatment for alcohol dependence. *Journal of Interpersonal Violence*. 2003;18(10):1113-31.
 37. Lee R, Kavoussi RJ, Coccaro EF. Placebo-controlled, randomized trial of fluoxetine in the treatment of aggression in male intimate partner abusers. *International Clinical Psychopharmacology*. 2008;23(6):337-41.
 38. Palmstierna T, Haugan G, Jarwson S, Rasmussen K, Nottestad JA. Cognitive-behaviour group therapy for men voluntarily seeking help for intimate partner violence. *Nordic journal of psychiatry*. 2012;66(5):360-5.

39. Taft C, Macdonald A, Monson C, Walling S, Resick P, Murphy C. 'Strength at Home' Group Intervention for Military Populations Engaging in Intimate Partner Violence: Pilot Findings. *Journal of Family Violence*. 2013;28(3):225-31.
40. Ernst AA, Weiss SJ, Hobbey K, Medoro I, Baker JJ, Kanter J. Brief intervention for perpetration of intimate partner violence (IPV): simulation versus instruction alone. *Southern Medical Journal*. 2011;104(6):446-55.
41. Houry D, Kaslow NJ, Kembell RS, McNutt LA, Cerulli C, Straus H, et al. Does screening in the emergency department hurt or help victims of intimate partner violence? *Ann Emerg Med*. 2008;51(4):433-42, 42.e1-7.
42. Rhodes KV, Lauderdale DS, He T, Howes DS, Levinson W. "Between me and the computer": increased detection of intimate partner violence using a computer questionnaire. *Ann Emerg Med*. 2002;40(5):476-84.
43. Trevillion K, Feder G, Agnew-Davies R, Byford S, Rose D, Howard L. A domestic violence intervention for mental health services: A pilot study. *Psychiatrische Praxis*. 2011;38.
44. Williamson E, Jones SK, Ferrari G, Debonnaire T, Feder G, Hester M. Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse. *Primary Health Care Research & Development*. 2015;16(3):281-8.