

# Receiving care for intimate partner violence in primary care: barriers and enablers for women participating in the weave randomised controlled trial

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**Receiving care for intimate partner violence in primary care: barriers and enablers  
for women participating in the *weave* randomised controlled trial**

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**Abstract**

**Background** Interventions in health settings for intimate partner violence (IPV) are being increasingly recognised as part of a response to addressing this global public health problem. However, interventions targeting this sensitive social phenomenon are complex and highly susceptible to context. This study aimed to elucidate factors involved in women's uptake of a counselling intervention delivered by family doctors in the *weave* primary care trial (Victoria, Australia).

**Methods** We analysed associations between women's and doctors' baseline characteristics and uptake of the intervention. We interviewed a random selection of 20 women from an intervention group women to explore cognitions relating to intervention uptake. Interviews were audio-recorded, transcribed, coded in NVivo 10 and analysed using the theory of planned behaviour (TPB).

**Results** Abuse severity and socio-demographic characteristics (apart from current relationship status) were unrelated to uptake of counselling (67/137 attended sessions). Favourable doctor communication was strongly associated with attendance. Eight themes emerged, including four sets of beliefs that influenced attitudes to uptake: (i) awareness of the abuse and readiness for help; (ii) *weave* as an avenue to help; (iii) doctor's communication; and (iv) role in providing care for IPV; and four sets of beliefs regarding women's control over uptake: (v) emotional health, (vi) doctors' time, (vii) managing the disclosure process and (viii) viewing primary care as a safe option.

**Conclusions** This study has identified factors that can promote the implementation and evaluation of primary care-based IPV interventions, which are relevant across health research settings, for example, ensuring fit between implementation strategies and characteristics of the target group (such as range in readiness for intervention). On

practice implications, providers' communication remains a key issue for engaging women. A key message arising from this work concerns the critical role of primary care and health services more broadly in reaching victims of domestic violence, and providing immediate and ongoing support (depending on the healthcare context).

Keywords: Process evaluation; intimate partner violence; Theory of Planned Behaviour; brief intervention

ACCEPTED MANUSCRIPT

## Background

Intimate partner violence (IPV) is a global public health problem that predominately affects women and their children (WHO, 2013a). Women exposed to IPV are frequent users of a diverse range of health services, and there is an urgent need to expand and improve the quality of evidence for interventions that could be offered to those identified through contact with health services (Garcia-Moreno et al., 2014; NICE, 2014; O'Doherty et al., 2015; Wathen & MacMillan, 2012; WHO, 2013b).

In light of this evidence gap, a study (*weave* trial; Victoria, Australia) was designed to assess the effect of a brief counselling intervention offered in primary care by family doctors to women exposed to IPV. The trial began with a postal 'health and lifestyle' survey to establish eligibility in 20,000 female patients aged 16–50 years attending 55 family clinics (Hegarty et al., 2010). Consenting women who were afraid of partners in the last 12 months were enrolled. Family doctors were then randomised to either intervention or control groups. Intervention group practitioners were trained in the provision of care for IPV (e.g. motivational interviewing and problem-solving techniques) and notified of participating patients, and then patients were invited (through a letter from their doctor) for up to six (30-minute) counselling sessions (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008). The primary outcomes were women's quality of life, safety and mental health. The *weave* trial focused on experiences of women as the majority of victims of IPV (Coker et al., 2002) and recognised that addressing IPV in other groups, including men (Williamson et al., 2015), may warrant alternative theoretical approaches.

As the gold standard for testing complex interventions, we used a (cluster) randomised controlled trial (RCT) to evaluate the *weave* programme. Trained doctors enquired more often about the safety of women and children at 6 months, and intervention group women

had fewer depressive symptoms at 12 months (Hegarty et al., 2013). However, clinically relevant differences in primary outcomes were not detected. We investigated whether the null effect on the primary outcomes reflected a lack of fit of the intervention to the problem or an ‘implementation failure’ (Rychetnik, Frommer, Hawe, & Shiell, 2002); for example, the counselling uptake rate was only 50%.

RCTs are limited in explaining implementation as it occurs, *how* trial end points are mediated and whether certain subgroups benefit over others. Not gathering/reporting such ‘process’ information indicates that practitioners and policymakers lack sufficient information to scale up/replicate ‘successful’ interventions (Moore et al., 2015).

Furthermore, the potential to meta-analyse trials and thereby strengthen the evidence base is undermined (Waters et al., 2011), because trial reports alone tend to lack sufficient information to help systematic reviewers critically compare and contrast interventions and their outcomes (O’Doherty et al., 2014). Moreover, process information may explain why some interventions unexpectedly fail, thereby promoting the effectiveness of future interventions. Here, we present findings from one of a series of process evaluation studies of the *weave* trial, focusing on women’s uptake of the intervention. More broadly, this work addresses the challenges and opportunities of delivering IPV interventions in (primary) healthcare.

In screening interventions that notify treating doctors of women’s positive abuse status, only around 50% of women actually discuss IPV with those providers (O’Doherty et al., 2015). In fact, in an emergency services subsample of a large Canadian trial (MacMillan et al., 2009), only 13% of women went on to disclose (Catallo, Jack, Ciliska, & MacMillan, 2013). Process evaluation demonstrated the role played by personal readiness, trust in providers, and fears about intrusion in women’s capacity to disclose to providers (Catallo et al., 2013). It highlights the complexity involved in delivering IPV



interventions and high susceptibility of implementation to contextual factors (Spangaro, Zwi, & Poulos, 2009; Wathen, MacGregor, Sibbald, & MacMillan, 2013). With therapeutic/support interventions then, varying rates of uptake relative to enrolment/randomisation have been observed. In a US antenatal trial, 59% of women received the minimum number of cognitive behavioural therapy (CBT) sessions (Kiely, El-Mohandes, El-Khorazaty, & Gantz, 2010). Tiwari and colleagues reported no discrepancy between the numbers enrolled and receiving a community-based advocacy intervention (Tiwari et al., 2010). Overall, however, little is known about women's response to therapeutic interventions, particularly in primary care by family doctors (Bair-Merritt et al., 2014); further, it is also important to be aware of what happens between enrolling a woman in a trial and actual uptake of the intervention.

The *weave* intervention (Hegarty et al., 2008) recognised that women attending primary care face a different situation from women traditionally involved in IPV interventions (e.g., refugee populations) (Sullivan & Bybee, 1999); for example, only 15% of participants had accessed IPV services in the previous year (Hegarty, O'Doherty, Astbury, & Gunn, 2013). As with intervention, implementation can also be informed by scientific theory (Moore et al., 2015); we used the theory of planned behaviour (TPB; Ajzen, 1991) to pre-empt issues that might undermine women's uptake. TPB is a social cognition model that proposes that a behaviour (in this study, *uptake* of an intervention) is a linear function of intentions and perceived behavioural control (PBC; perceptions about control over performing the behaviour). Intentions, then, are viewed as a function of three types of cognitions: attitudes (degree to which she favourably or unfavourably evaluates the behaviour), subjective norms (beliefs about whether peers think she should engage in the behaviour) and PBC. TPB is mostly used to predict health behaviours such as physical activity (Hardeman, Kinmonth, Michie, & Sutton, 2011) and eating (Riebl et al., 2015). Although it has been used to understand cessation of IPV/dating violence and relationship

termination (Rhatigan, Street, & Axsom, 2006) as well as help seeking in areas such as mental health (Chen, Romero, & Karver, 2015), using the theory to make sense of help seeking in IPV survivors is not common. In *weave*, TPB led to personalised invitations and sessions being delivered free of charge by doctors who were locally based and known to participants. Yet, barriers persisted for the women. Here, we aim to understand the individual and contextual factors involved in women's decisions to attend (or not) their family doctor for brief counselling.

### Methods

The primary source of data for this study was derived from semi-structured interviews with a selection of women who had completed their participation in the *weave* trial (Hegarty et al., 2013). We examined quantitative metrics related to the patterns of uptake to provide additional contextual information. Originally, 137 women were invited to counselling; 67 (49%) of these women received a dose (one to six sessions). We compared characteristics (assessed at recruitment/baseline) of women who took up sessions and those who did not, using marginal logistic regression for binary variables and marginal linear regression for continuous variables. We also explored doctor characteristics (Table 2) and the stages of change in the women interviewed (Table 3) as additional background information. Generalised estimating equations with robust standard errors were used to adjust for correlated responses at the doctor level. Multinomial logistic regression was used for outcomes with three or more categories, and then adjusted for correlated responses at the doctor level using the `svy` command in Stata (version 12) (StataCorp, 2011). This study was approved by the Human Research Ethics Committee of The University of Melbourne.

### Interviews

Upon completion of the 2-year trial follow-up, 31 women from the intervention group (23%) had withdrawn or could not be contacted. We randomly selected 20 women from

the remaining 106 and invited them to be interviewed (all women approached agreed). Two authors conducted interviews (May to December 2012) at participants' homes or nominated locations; four women were interviewed by telephone due to distance/time constraints. Participants provided informed consent. The average duration was 36 minutes (range 16–50 minutes). Women were offered a \$30 voucher as an honorarium. We examined interviewees' baseline characteristics (age, abuse exposure, level of fear and readiness for change) and patterns of uptake to check the representativeness of the sample relative to the full intervention group. Interviews were audio-recorded, transcribed, de-identified and entered into NVivo 10 (QSR International, 2011).

### **Qualitative Analysis**

We mapped data to the most appropriate overarching, first-order TPB factors. Then, we generated inductively second-order themes within each category: (1) behavioural beliefs that led to favourable or unfavourable attitudes towards uptake, (2) control beliefs that influenced women's PBC and (3) normative beliefs reflecting what women thought others would think about the counselling. These beliefs would lead to formation of an intention, and given a sufficient degree of actual control, women would be expected to carry out their intentions when the opportunity arose (Ajzen, 2002). The authors met on two occasions during data collection to check the internal validity of data, fit of the model and initial cross-coding and to discuss emergent themes. Once all 20 transcripts had been coded, the authors met to determine whether thematic saturation had been achieved by examining the strength of data linked to second-order themes and determining any apparent additional emergent themes (Patton, 2002).

### **Results**

The women who took up counselling as part of the *weave* programme did not differ from those who did not in terms of baseline characteristics. However, the attenders were less

likely to be in a current relationship (Table 1), and they rated their doctors' communication skills (GPAQ; Mead, Bower, & Roland, 2008) more favourably (Table 2).

### INSERT TABLE 1 ABOUT HERE

Compared to the intervention group overall, the 20 selected women may have been less open to help from a doctor for IPV (55% vs. 73%) and they less often regarded the *weave* doctor as their 'usual' doctor (45% vs. 63%) (Table 2). Ten interviewees had actually attended sessions. Next, we present the findings from interviews under the three sets of TPB cognitions, with Table 3 providing some contextual information on the women's stage of readiness.

### INSERT TABLE 2 ABOUT HERE

#### Behavioural Beliefs

We explored women's cognitions that led to favourable or unfavourable attitudes towards accepting the *weave* intervention, such as perceived value of receiving help for IPV, what it would mean to receive this care from a family doctor and outcomes of attending the counselling. Four second-order themes emerged:

**Awareness ('I am scared. I am not safe now').** As anticipated, women entered the *weave* programme with varying degrees of awareness of their partner's abusive behaviour (all stages of readiness were represented; Table 3). However, a belief that her partner's behaviour towards her was problematic (even it had not been fully named as abuse) was a prerequisite for participating in the counselling programme. An unintended effect of the research was its influence on women's awareness of the abuse, shaping help-seeking cognitions and increasing openness to seek help. One woman explained the project had 'multiple, multiple effects. I think it was an interesting gauge for myself with how I was feeling over the four years; I could watch myself become less and less scared,

and more assertive, realise what I wanted. It was quite therapeutic, and especially at the very start where I actually forced myself to acknowledge: I am scared. I am not safe now' (P12). Another participant indicated that the survey questions 'made me perhaps a little bit more accountable, a bit more responsible too, rather than, it's just this thing' (P19).

### INSERT TABLE 3 ABOUT HERE

**An avenue to help (receiving the invitation 'just felt like I had support').** The invitation to the counselling often represented a turning point for women who were ready for help even if they had not fully recognised the abuse; it alerted them to a new possible option for accessing support. For one participant, it 'opened up that Pandora box, because there'd never been the linkage that there was so much, such big issues here. I'd kept that very close to myself. Even my girlfriends - no one knew' (P5). As intended, the invitation influenced women's cognitive appraisals of their circumstances, initiating what was for some women their first experience of formal help seeking. One participant explains, in relation to receiving the invitation: 'it felt good. I wasn't going silly. I wasn't mental. It's more or less verification. Once you have that, you can move on. It's very hard to move on if it's not acknowledged' (P28). Their accounts highlighted difficulties separating the research process from the intervention in relation to what triggered help seeking and intervention uptake. Completing surveys and other aspects of the research possibly influenced beliefs about the relationship and help seeking, in addition to priming women for when the invitation was received. For one woman, the project 'brought up things and none of it was negative, it was all positive. I felt empowered, remembering issues and how I dealt with them. It helped me to self-reflect. It was also the *weave* project – doing that first questionnaire – gave me the strength to go and seek help for my depression' (P18). Non-attenders included women who did not favourably evaluate taking up the intervention, believing it could cause them harm (see next theme) or not benefit them; for example, two women had sufficient family support, seven women were getting help from

other healthcare providers and four women were receiving adequate support from other family doctors ('the fact that he listened and could see that I was upset. He was empathetic. He supported me. I don't know that it was actually about necessarily relationships' (P18)). One woman explained about talking to her doctor: 'She was the one who said, "why are you suffering? There are options that you have to consider." She was very helpful' (P20).

**Health providers' communication and women's assessments based on historical encounters ('you need a good listener').** A powerful cognition influencing uptake behaviour involved women drawing on what they understood about their family doctor from clinical interactions that predated the *weave* project. One woman explained: 'he always has let me know that if I ever need to talk, that he's always available and always there for us, a helping hand, a bit of guidance, a bit of support' (P28). Although targeting doctors' communication skills was a key feature of the provider-level intervention, women made decisions to attend sessions in the context of a prior relationship and previous encounters. It was well evidenced that women only entertained taking up the intervention where the *weave* doctor possessed certain communication skills: 'I definitely trusted her and she's a very caring person. That was really important to me because I hadn't dared tell anybody about this before' (P8). Women referred to doctors' qualities as 'very compassionate, very understanding' (P28) and the need for 'a rapport with them so that I can see whether I can or cannot trust them in regards to that type of thing, which is very different from general health things' (P16). It was apparent that women developed trust (that would inform their decision to take up the intervention) based on having witnessed doctors' knowledge and communication skills: 'she was the one who basically saved my life. It was through her carefulness that this thing was found. So my trust and confidence in her as a doctor was obviously right up there' (P2). Conversely, women who negatively appraised doctors tended not to take up the

intervention. One woman thought her doctor's 'knowledge was poor' and 'when someone doesn't listen, it's very hard to communicate. You need a good listener. You need to have it reflected back to you. It was like she was trying to undermine me as a patient. That's how I felt. I felt undermined, bullied, and it was terrible' (P18). Another participant also reported a negative experience: 'It was like "you've been raped, now get over it" and I'm like "hang on a minute, you haven't lived in my shoes" – To me, she hasn't got the understanding of being raped' (P7).

**The doctor treats physical problems only ('I didn't think of my GP as a counsellor').** Although this barrier to uptake was anticipated and was countered in the invitation, the women widely held the belief that the role of the family doctor is to address a person's medical problems. One woman who routinely saw counsellors to discuss her experience of IPV indicated 'A GP is like medically-trained and I go there if I feel sick' (P6). Similarly, it was common for women to perceive the role of GP to 'prescribe medications and check your temperature and fix physical things' (P26). This woman went on to say that she 'didn't realise how many links a GPs can actually have to help personal stuff'. There was an indication that women (who trusted their doctor) could change their view about the doctor's role: 'I felt a bit odd sitting there with people coughing and sneezing next to me. But I'd known my doctor for a long time and I trust doctors. I have gone to doctors in the past with things to talk about. Issues with the kids or whatever. So yeah I felt a little bit odd but mostly comfortable doing that' (P8). There was evidence that women's views on the role of the doctor were malleable and were influenced by the characteristics of the study (e.g., communication with the research team) and intervention components such as content of the invitation. One woman described realising doctors are there 'for more than just physical conditions. But how do you start? When you go in to a GP, how do you say, "I haven't got a broken arm, I've got a broken heart?" You wouldn't think to go to a GP for that. You'd think of going to a psychologist or a psychiatrist or a

counsellor. How can you say “I’m hurt, but I’m hurt all over?” (P1). Thus, even despite an openness to discussing IPV with trusted doctors, other barriers to disclosure persisted.

### **Perceived Behavioural Control**

We examined control beliefs that contributed to women’s perceptions on control over attending the sessions, which involved tapping into self-efficacy (cognitions about the ease or difficulty of taking up the intervention) and controllability (cognitions on the extent to which attending counselling was up to the woman herself).

**Emotional health as a barrier (‘caught up in the emotional stuff’).** Despite their awareness of difficult relationship circumstances, women’s poor emotional well-being and chaotic lives often prevented them from accessing help, both generally and in terms of opportunities presented by *weave*. The following quote captures the many factors that added to feelings of powerlessness and reduced self-efficacy. This woman who had made an appointment, but later cancelled it, explained, ‘I was embarrassed with how I looked. Prior to that when I was studying, I used to be proud of how I looked. I looked quite disgusting. I was very, very skinny. So I didn't want to go out, to talk to anyone. So I was aware of them [services] but (a) you are caught up in the emotional stuff (b) you are embarrassed and (c) I knew it all already. I knew it in theory. I knew what I had to do and how to do it. It was just getting the courage to do it anyway, which is something that they wouldn't have been able to do for me. It was literally up to me and I knew it’ (P12).

**Managing disclosure (‘I wouldn’t know where to start’).** Similarly, fears about managing the encounter with the doctor were common in women’s narratives and supplanted women’s intentions to accept the opportunity for help. One non-attender explained, ‘I think it's always nerve-wracking to go speak to someone about feelings that are going on inside you. Do I open up to someone when you're not very good at doing that? It's quite difficult. But I don't think there were any barriers other than all those



uncomfortable things to do' (P23). This theme captured concerns about not being able to communicate the issues effectively and dispassionately; together with perceiving time constraints in family practice (next theme), the theme worked against women's sense of control to utilise the *weave* sessions to benefit their situation. Another woman who attended a number of sessions explains her reaction to the initial invitation: 'When it came in the mail I thought I would do that. Yeah I was pleased to go in and do it. I was a bit apprehensive about it. About what she was going to ask and I was concerned that I might cry because I don't like crying in front of people' (P8).

**Time ('he was a really busy doctor').** Although the *weave* programme enabled six 30-minute sessions, perceptions about doctors' lacking time persisted as an 'external' barrier to women's engagement. A woman who did not take up sessions refers to early perceptions about the doctor's time (and role expectations): 'What I imagine a GP would do would be to say okay, "there are some issues there. We've only got 14 minutes and five seconds and I'm going to refer you to a psychologist or a relationship counsellor."' So I was thinking how can he fix this with the time constraints you have with GPs' (P26). Women reported actual challenges in booking long appointments, which reduced women's control over attendance, 'He is a good doctor, he has a lot of patients and I had to put it down as a long appointment, which weren't always available. I had a few appointments with him. But he was a really busy doctor and I felt as though he didn't have much time' (P30).

**A safe place ('A GP visit is quite innocent').** In contrast to control beliefs on time availability, receiving care for IPV in primary care conferred a sense of control over the help-seeking process. In particular, it was a 'safe' option that would attract minimal attention from partners. Participant 12 who did not recall receiving the invitation from the doctor 'because it was such a hectic time' indicated: 'When you are in that situation, your phone's been gone through, your emails, your mail, you have no privacy whatsoever. So if

you make contact with an external service, they [partners] would want to know. Whereas a GP is an innocent visit for a physical check-up. It is not a lie, but it is a fantastic way to get those 15 minutes of space to go, “bluh, this is what's happening, for the love of God, help me” (P12). Another unanticipated effect was the research itself being used to explain frequent visits to the doctor: ‘Because I was having them regularly my excuse was it was just part of the research; he didn't ask me too many questions and I just went, “oh, it's just about women's health”. So he hadn't even clicked that it was more about being under an abusive controlling environment’ (P5).

### **Subjective Norms**

In terms of themes of awareness, readiness for change and locating an avenue for help, it was clear that for many women the *weave* intervention was an antidote to social norms that had encouraged them to conceal their experience of IPV. For example, one woman told how she had kept the abuse ‘very close to myself. Even my girlfriends – no one knew’, and referred to the *weave* sessions as her opportunity to open ‘that Pandora’s box’ (P5). Another woman shared that her trust in the *weave* doctor ‘was really important to me because I hadn't dared tell anybody about this before’ (P8). Thus, we see that the majority of women participating in this research programme were motivated to hide the abuse, and that the intervention and other unintended effects of the research normalised the help-seeking process. However, we did not gather much evidence under subjective norms, where women had solicited the views of peers as part of making a decision to take up the *weave* intervention.

### **Discussion**

With increasing focus on the need for more evidence on health-based interventions to tackle IPV (NICE, 2014; Wathen & MacMillan, 2012; WHO, 2013b), this study, a process evaluation of the *weave* trial (Hegarty et al., 2013), identified factors that

influenced survivors of IPV to take up a counselling intervention in primary care. Context has important implications for implementation and outcomes (Moore et al., 2015) particularly in trials of complex issues. Thus, in building multidimensional perspectives on the *weave* trial in a series of process evaluative studies, contextual issues related to intervention uptake needed to be explored. A broader goal of this work was to inform the development of future IPV interventions.

Women who attended sessions were less often in a current relationship, although no differences were observed in the severity of abuse, education, or employment compared to non-attenders. Qualitative analyses identified four TPB cognitions about the perceived value of the intervention in women's lives, and four reflecting the control women perceived themselves to have over enacting the behaviour of interest, that is, uptake of the intervention (PBC) (Ajzen, 2002). The *weave* intervention (Hegarty et al., 2008) recognised that not all abused women have the capacity or are ready to access specialist IPV services (Chang et al., 2010; Cluss et al., 2006; Feder et al., 2011; Zink, Elder, Jacobson, & Klostermann, 2004), but they may benefit from help in primary care (Garcia-Moreno et al., 2014). Women in this study largely supported the local primary care context as viable. The *awareness* theme did suggest, however, that being in a pre-contemplation stage was a powerful barrier (Reisenhofer & Taft, 2013). Conversely, awareness was dynamic and related cognitions were responsive to research participation. The *weave* programme represented an *avenue to help*, benefitting both those currently/recently victimised and those who had been exposed to violence in the past. *weave* enabled women to experience a certain level of control over help seeking (O'Doherty, Taft, McNair, & Hegarty, 2016) – obtaining help in primary care was seen as a *safe* option (a control cognition) where the everydayness of attending the family doctor allowed discrete participation. Consistent with studies on creating conditions for disclosure (Feder, Hutson, Ramsay, & Taket, 2006), the participating doctor's

*communication skills* were hugely influential in decisions to attend. Supporting this, the quantitative analyses showed a difference in the appraisal of doctors' communication between attenders and non-attenders at trial entry. Although we emphasised the doctor's interest in supporting women for 'emotional and relationship issues' in the invitation, the belief that *doctors treat physical problems only* reduced engagement. Poor *emotional well-being* (which fed into reduced self-efficacy) was seen as a barrier to women's engagement. Two final control cognitions that were obstacles to uptake were perceiving doctors as *time-poor* and concerns about the implications of opening Pandora's Box and managing *disclosure* in the consultation context. Finally, with respect to cognitions derived from social norms, it is acknowledged that these contribute to both IPV victimisation and reduction in women's capacity to seek help (O'Doherty et al., 2016). While evidence from the *weave* trial has previously demonstrated that the study (and intervention) characteristics could counter the adverse impact of social influences (Valpied et al., 2014), social influence via direct interactions with others in the woman's network did not emerge in the current analysis as a factor specifically affecting decisions to take up the intervention. This may reflect a continued motivation to conceal the abuse experience in certain contexts even after accessing formal support (O'Doherty et al., 2016).

### **Research Implications**

Our study suggests that an established, good-quality relationship with the provider may enhance implementation of interventions for IPV across a range of healthcare services. Therefore, settings characterised by infrequent/once-off encounters may find engaging women more challenging; for example, Catallo and colleagues (2013) referred to the 'intrusiveness' feared by women offered a screening intervention in emergency departments. The women in that study anticipated a cascade of unwelcome actions from

disclosure, in contrast to the *weave* experience, which highlights a distinct set of barriers around perceived control that may be characteristic of certain health contexts.

Intervention uptake can be encouraged by establishing early whether participants would even be open to an offer of help from a specific provider/setting. Alternatively, inflating the sample size based on an uptake rate estimate may be a solution.

The relative low visibility of primary care as a way of reaching victim/survivors and responding to IPV is a key implication in a field that demands constant attention to risks and harms (Hartmann & Krishnan, 2014). Mental health needs to be accommodated as a barrier to participation, particularly for interventions in pre-specialist settings where contact with support services may be minimal/absent. More intensive lead-up feasibility work (Wuest et al., 2015) may have led to the *weave* invitation more effectively providing the necessary counterevidence. A more intensive 'systems' interventions could involve training multiple practitioners (creating more options for intervention) and demonstrating commitment to supporting psychosocial/relationship concerns in a warm-up phase.

Flexible approaches to delivering the intervention may also have increased reach, for example, telephone support/counselling (McFarlane, Groff, O'Brien, & Watson, 2006; Tiwari et al., 2012).

The need to disentangle the effects of an intervention as intended from other changes engendered by the research process (e.g., participating in a programme focused on IPV, acknowledging IPV as unacceptable and deserving of research/clinical attention and raising awareness through data collection methods) is a key implication of this work. We reported on the experience of completing *weave* surveys in both intervention and comparison groups and its association with personal readiness to address IPV (Valpied, Cini, O'Doherty, Taket, & Hegarty, 2014). Thus, constant attention to balancing ethical and safety requirements, retention strategies (e.g., contaminating effects of using

honoraria and intensive follow-up) and evaluation processes with pragmatic research practice is essential to promote successful replication in real-world settings.

### **Practice Implications**

The finding that women taking up *weave* counselling were less often in relationships suggests the need to create multiple entry points to IPV care at an earlier point in abuse trajectories. Although ‘pre-contemplative’ women remained hard to reach, primary care does appear to offer a distinct advantage over other settings (Garcia-Moreno et al., 2014) for connecting women with accessible, discreet, and non-threatening formal support before women reach the point of crisis. Of course, ensuring that care provision is adequate and safe is paramount, emphasising the need to train family doctors in asking and responding to women with signs and symptoms suggestive of IPV and according to their stage of readiness. In addition, if primary care is to be viewed as an avenue to help, provider/clinics need to make their commitment to supporting patients with these concerns more visible. To overcome the perennial challenge of providers’ time availability, and barriers created by low awareness (e.g., on links between domestic violence and their own or children’s poor health) and fears about disclosure, providers could offer follow-up consultations (if it is safe to do so) as a part of supporting adults affected by violence. Our study also inadvertently suggested the power of simple, ongoing, practice-based awareness-raising strategies (e.g., using posters and other approaches that establish relationship/domestic safety as a healthcare value) to normalise talking about IPV to healthcare providers. However, when it comes to the ‘work’ of escaping violence and increasing safety, more sophisticated support is required to problem-solve the many obstacles faced by victims. Our study has pointed to the central role of providers’ communication in encouraging help-seeking, disclosure and women’s ongoing capacity to engage in support interventions. This underscores the value of

promoting communication in tertiary-level and practice-based training (Valpied & Hegarty, 2015).

### **Limitations and Strengths**

'Intentions' were beyond the scope of this work, and we captured uptake but not 'engagement'. The TPB is limited in addressing factors such as fear, threat, mood, past experience, automatic responses, emotional processing and impulsivity (Michie, van Stralen, & West, 2011), psychological processes likely to be central to the experience of a complex issue such as IPV. Moreover, the theory does not account for environmental/economic factors that may influence uptake, and linear decision-making is assumed. There was potential for recall bias; moreover, the most vulnerable women were absent from the study – those with more severe mental health issues or disabilities, those from linguistically and culturally diverse backgrounds and those struggling to access services in their community on account of the isolation or control they experience. The health literature is replete with models to guide process evaluation (Moore et al., 2015; Oakley et al., 2006; Pawson & Tilley, 1997); however, our study provides information specific to investigating health-based IPV interventions. No woman interviewed described a harmful experience outweighing the benefits for her, and the women reflected a sense of choice with respect to research participation and taking up the intervention, consistent with analyses across the full sample (Valpied et al., 2014).

### **Concluding Remarks**

The study identifies specific factors of note in implementing and evaluating primary care-based IPV interventions. There is a need to ensure a fit between characteristics and capabilities of the intervention setting and the target group's cognitive appraisals and readiness for intervention. We support embedding theory-informed, mixed-methods

process analyses into trials to identify early potential difficulties in recruitment, retention, intervention delivery and uptake. We also urge greater attention to potential interactions between study characteristics and implementation and outcomes. Providers' communication remains a key issue for engaging women experiencing IPV in research and practice contexts. A key message arising from this work concerns the critical role of primary care and health services generally in reaching victims of domestic violence, and in providing immediate and ongoing support (depending on the healthcare context), including facilitating crucial links with services that can restore the rights of adult and child victims to domestic safety.



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ACCEPTED MANUSCRIPT



**Table 1. Baseline characteristics of the intervention group: Non-attenders, attenders and women interviewed.**

<b>Baseline Characteristics</b>	<b>Non-attender (N = 70)</b>	<b>Attender (N = 67)</b>	<b>Estimate (95% CI)<sup>a</sup></b>	<b>Women interviewed (N = 20)</b>
Age <30 years	17 (24%)	10 (15%)	2.0 (0.7–5.5)	4 (20%)
Born outside Australia	14 (20%)	15 (22%)	0.9 (0.3–2.3)	4 (20%)
High school not completed	29 (42%)	22 (33%)	1.5 (0.7–3.1)	6 (30%)
Not employed full/part time	15 (26%)	17 (28%)	0.9 (0.5–1.7)	12 (75%)
<i>Marital status<sup>b</sup></i>				
Never married (base category)	31 (45%)	19 (29%)	-	6 (30%)
Married	14 (20%)	19 (29%)	2.2 (1.1–4.6)	9 (45%)
Separated, divorced or widowed	24 (35%)	27 (42%)	1.8 (0.9–3.5)	4 (20%)
Welfare main income source	13 (19%)	16 (25%)	0.7 (0.3–1.7)	2 (11%)
Current intimate relationship	52 (74%)	40 (60%)	1.9 (1.0–3.7)*	16 (80%)
Children <18 years old at home	39 (57%)	37 (55%)	1.1 (0.5–2.1)	12 (60%)
<i>Intimate Partner Violence</i>				
Fearful most or all of the time	9 (13%)	12 (18%)	0.7 (0.3–1.7)	1 (5%)
CAS score $\geq 7$	52 (75%)	49 (74%)	1.1 (0.5–2.3)	12 (60%)
<i>Abuse types (CAS)<sup>c</sup></i>				
No abuse (base category) <sup>d</sup>	9 (13%)	5 (8%)	-	2 (10%)
Severe Combined Abuse	22 (32%)	20 (30%)	1.6 (0.4–6.0)	9 (45%)
Physical & Emotional Abuse	22 (32%)	18 (27%)	1.5 (0.4–5.1)	4 (20%)
Emotional Abuse only	15 (22%)	22 (33%)	2.6 (0.8–8.9)	4 (20%)
Physical Abuse only	1 (2%)	1 (2%)	1.8 (0.1–50.8)	1 (5%)

**Notes.** \* $p < 0.05$ . General characteristics are summarized as  $n$  (%). Some denominators vary due to missing data. CI = Confidence interval. CAS = Composite abuse scale (K. Hegarty, Bush, & Sheehan, 2005).

<sup>a</sup> Odds ratios for binary and categorical variables, and mean differences for continuous variables; All estimates and CIs are adjusted for correlated responses at the general practitioner/family doctor level.

<sup>b</sup>  $F(2, 23) = 3.1, p = 0.06$  (not significant). <sup>c</sup>  $F(4, 21) = 1.3, p = 0.31$  (not significant).

<sup>d</sup> Although all *weave* participants were afraid of a (ex)-partner in the last 12 months (used as trial inclusion criterion), a proportion of women scored negative on the CAS for current abuse.

**Table 2. Family doctor characteristics and women's patterns of attending.**

<b>Family Doctor Characteristics</b>	<b>Non-attender (N = 70)</b>	<b>Attender (N = 67)</b>	<b>Estimate (95% CI)<sup>a</sup></b>	<b>Women interviewed (N = 20)</b>
Female	49.0 (70%)	40.0 (60%)	0.99 (0.98–1.00)	14.0 (70%)
Rural	22.0 (31%)	19.0 (28%)	1.00 (0.98–1.03)	4.0 (20%)
Communication <sup>b</sup>	77.9 (20.5)	85.0 (17.3)	6.7 (0.3–13.1)*	79.3 (26.2)
<i>Doctor care</i>				
weave doctor as usual doctor	44.0 (63%)	42.0 (63%)	1.00 (0.5–1.9)	9.0 (45%)
Open to help from family doctor <sup>c</sup>	48.0 (69%)	52.0 (78%)	0.60 (0.3–1.4)	11.0 (55%)
Attended >1 weave sessions	—	34.0 (51%)	—	6.0 (30%)

**Notes.** \* $p < 0.05$ . General characteristics are summarized as  $n$  (%) or Mean ( $SD$ ). Some denominators vary due to missing data. OR = Odds ratio. CI = Confidence interval.

<sup>a</sup> Odds ratios for binary and categorical variables; mean differences for continuous variables. All estimates and  $CI$ s are adjusted for correlated responses at the general practitioner/family doctor level.

<sup>b</sup> Rated by trial participants at baseline using GPAQ (The General Practice Assessment Questionnaire). Scores are percentage of maximum score of 100.

<sup>c</sup> Item assessed openness to help for fear of partner in the eligibility screening survey; women could respond yes/no/not applicable.

**Table 3. Stage of ‘readiness for change’ for women interviewed**

<b>Participant</b>	<b>Stage of Change at Trial Baseline</b>	<b>Stage of Change at Interview</b>
P1; attended 1 session only	Contemplation	Maintenance; woman separated from husband and is no longer fearful of him.
P2; attended >1	Contemplation	Maintenance; she reported an abusive relationship from 20 years ago and her current husband was also emotionally abusive. The <i>weave</i> doctor gave her strategies to deal with current relationship.
P5; attended >1	Pre-contemplation	Action; separated from husband since project started and now they are receiving couple counselling.
P6; non-attender	Action	Action/maintenance; woman separated from partner since project started.
P7; non-attender	Maintenance	Maintenance; this woman still experiences fear from relationship 20 years ago.
P8; attended >1	Maintenance	Maintenance; was fearful of ex-husband from 20 years ago but had not previously disclosed. She is less fearful now and learned strategies for managing conflict.
P11; non-attender	Contemplation	Action; in interview, woman described past relationship. However, survey data suggested she experiences fear in her current relationship. Interview constrained by presence of family.
P12; non-attender	Preparation	Maintenance; separated from partner since project started, supportive parents and had little recall of the invite.
P13; non-attender	Pre-contemplation	Contemplation; still in the relationship but less fearful than previously. She described current emotional abuse. She copes by having low expectations. She appreciated invite but was discouraged as she and partner visit same doctor so she spoke to another doctor.
P16; attended 1 session only	Maintenance	Maintenance; separated
P18; non-attender	Contemplation	Action/maintenance; she has feared a number of partners including current. She was less fearful at follow-up and empowered to make changes by the project (though not by doctor).

Participant	Stage of Change at Trial Baseline	Stage of Change at Interview
P19; attended 1 session only	Contemplation	Action; still in the relationship with person who made her fearful, but is more in control, and regularly reflects on her situation and remakes decision to stay. She is 'not responsible for his behaviour'. Practices strategies such as leaving house if she/children feel unsafe.
P20; non-attender	Pre-contemplation	Action/maintenance; She did not recall the invite and is now separated. <i>weave</i> had minimal impact; she went to her usual doctor who provided good care, and referred her to a psychologist.
P21; non-attender	Contemplation	Maintenance; she ended the relationship. She has mental health issues, which she manages with support from a non- <i>weave</i> doctor and psychologist. She did not recall invite, but at that point had already made the decision to change clinics.
P22; attended 1 session only	Maintenance	Maintenance; divorced since <i>weave</i> commenced. Currently, in new relationship and no longer fearful.
P23; non-attender	Contemplation	Contemplation/preparation; still experiences fear at times but says it is less than before. She has had counselling since referred during <i>weave</i> project.
P26; non-attender	Contemplation	Maintenance; no longer in relationship, separated since start of <i>weave</i> .
P27; attended >1	Action	Action; woman was afraid of an ex-partner. She also experienced problems with her new partner. The <i>weave</i> doctor helped her.
P28; attended >1	Action/maintenance	Maintenance; she separated from violent ex-partner. He continues to see their child.
P30; attended >1	Contemplation	Woman is in relationship with the partner she previously feared, each receives counselling and the relationship has improved.

**Highlights**

- Women exposed to intimate partner violence (IPV) are open to help in primary care
- Implementation strategies need to fit with the complex characteristics of the target group
- Doctor communication is a key factor influencing the uptake of doctor-delivered IPV interventions
- Research context has a strong potential to interact with implementation and outcomes