

## Supplementary Material: Health Professional Triple R Pathways

This supplement presents the complete set of participant Triple R Pathways following complexity-led discourse analysis. This data must be read together with the paper ‘Exploring sustainable primary care responses to intimate partner violence in New Zealand: Qualitative use of complexity theory’, to adequately understand how the complex adaptive system approach is used to explore intimate partner violence responsiveness in primary care. Below, the Triple R Pathways are grouped by general practice. Descriptors of the practices may be found within the paper. Tables 1, 2, 3 and 4 summarise the participant *respond* stance and *response* discourse.

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### 1.1 Whānau Oranga (Family Health)

Table 1. Participant *respond* stance and *response* discourses

Participant	Respond	Response
Rachel, Nurse Practitioner	I just want to make a difference	Making sure I know what to do
Mark, General Practitioner	It’s a very sensitive topic to talk about	It’s very hard
Tina, Administrator	You have to show empathy and help the patient	Every patient is going to be different
Tania, Nurse Mere, Social Worker	The current resources don’t change people’s situation	It is different for us being Māori
Mary, Practice Manager	The clinic isn’t adequately resourced to manage the mix of health and social problems	We’ve only got so much capacity
Moana, Primary Health Organisation Manager	We are redefining health in a different framework	It’s not a priority

#### Rachel, nurse practitioner.

Rachel’s *response* discourse ‘making sure I know what to do’ is driven by a passionate *respond* stance of ‘just wanting to make a difference’. Rachel felt challenged initially to address IPV because she was not comfortable to ask and did not know what to do about it. This was amplified when she began working at this practice.

To come into this practice and 60% plus of our women and some of the men have been exposed [to IPV] it was a bombshell really. It was difficult to start with because a lot of it was to do with mental health and sexual abuse. I’d done some work throughout my nurse practitioner training around how to cope, how to manage and help patients manage so I’d already had some knowledge around that, but it was emotionally taxing, more than I expected. It’s so infiltrated into particularly the Māori population and we see a lot of that here.

This environment changed the way she looked at a problem and the way she practiced. Her *respond* stance motivated her to identify people that need help. ‘Just wanting to make a difference is probably the biggest thing. [...] seeing the amount of need out there, particularly for this patient population’. This was reinforced when she was able to help someone, supported by access to community services.

I had a guy come in on Thursday and no money, partner used the benefit money for drugs, no food, didn’t know where he was going to go, was in crisis. Didn’t go to the

ED, came down here, crying in the corridor. I could immediately run [location] and find out when the social worker was going to be back, I could give him a food parcel for the weekend and he knew that he could come back if he needed to. There are some general practices that that couldn't have happened then and there, and we might have just referred him through to crisis team mental health. But because we could do it here, and he trusted us as his health care provider, that made a difference to him immediately rather than sending him somewhere else or waiting. I mean you'd have to ask him from his perspective whether it was actually that good, but it felt good from my perspective because I could do something.

Similarly, Rachel feels challenged to make a difference when poor communication with community services makes referral difficult.

We can make referrals, but it doesn't feel like you've made any in-roads into making a difference and integrating into that. [...] I wonder whether it's a lack of understanding of how general practice works from the inside outside? The interface is not linked somewhere?

'Just wanting to make a difference' directly, and strongly, influences Rachel's *response* discourse of 'making sure I know what to do'. Feeling challenged to respond effectively motivated her to educate herself, voluntarily, on how to do that. 'I'm very, very focused on improving my knowledge and skills all the time, not just thinking I know enough because you never do you when you work in this sort of environment.' She needed to make sure she knew what to do to be able to make a difference, illustrating the strength of the relationship between her *respond* stance and *response* discourse.

Rachel's strong *respond* stance and *response* discourse positively influence her *responsiveness*. Faced with a complex problem, she was motivated to take steps to ensure the provision of good care, while managing the doubt involved.

Always in general practice you live with that level of discomfort, that level of uncertainty. Because sometimes you're never really sure that that's the right diagnosis, but you trust your training, your instincts and the patient's history to go down a particular course.

Rachel tries to generate a responsive pattern of interaction to make a difference for her patients. Yet other system interactions block her attempts. She calls attention to the general practice funding model as a main constraint in implementing new things. She believes the practice can be more responsive, such as referring patients to the community services, but the funding model blocks transformation to a different model of care, such as Whānau Ora. She says, 'I don't think within the clinic here we are focused any differently from any other general practice sadly, although we do see a very different population'. Rachel is driven by a personal desire to make a difference for people, which generates beneficial outcomes both for herself and her patients. However, these interactions are being blocked from self-organising into a positive and repeated pattern by other system interactions outside of her control.

### **Mark, general practitioner.**

Mark's *response* discourse 'it's very hard' recognises the number and diversity of issues patients consider when disclosing IPV and how this influences the response options available to him. His *response* is informed by his *respond* stance, 'it's a very sensitive topic to talk about', learnt from his experience consulting with patients. In his *respond* stance, Mark views IPV as different to other health issues due to stigma and sensitivity, often finding himself as the patient's 'sole trust person'. Trust and confidentiality are very important, and he believes a GP room is a safe place to disclose. 'Sometimes they come with the pretext of health issues and then they start crying [with] the real issue, then they decide to tell you what the problem is.'

Mark's *respond* stance can negatively influence his practice. For example, if the patient has restricted what he can do to help (e.g. don't tell anyone), he can feel alone in dealing with that. 'You feel that weight, the big burden on your shoulder'. The environment of Whānau Oranga can exacerbate this. Mark will try to keep the 'story' to himself because of confidentiality concerns. He feels he cannot debrief with staff and is also wary of entering too much information in the patient management system.

Mark's *respond* stance also positively influences his *response* discourse by recognising how difficult it is for people to talk about it, or to change their situation. He knows his patients may be ashamed to talk about it, worried about the consequences, what might happen to the partner, what happens if the breadwinner goes to jail or whether the partner will still be involved with their children. He says 'all of this can affect their decision' of what to do, shaping what response 'options' are available. He feels like, 'most of the time the answer they give me, I feel like they are trapped, they've got nowhere else to go. Yeah, there aren't many choices. I think it's very hard.' Mark believes the best thing he can do as a doctor is to identify the problem as fast as possible and refer onto other services. He is also conscious of not extending the consultation time as 'you have to charge them more, which they usually don't want, or they can't afford.'

Mark maintains his boundaries as 'identify and refer' so he doesn't become too emotionally involved in the patient relationship.

It did happen actually with one of my patients, there was a couple from [overseas] they were having trouble to get immigration, to get residency to live in New Zealand, and ah and apparently the husband was a bit violent towards the wife as well and each time, each time they came to the consult he wouldn't allow the wife to talk. But then one day I decided to ask the husband to stay outside so I could have a chat with the wife and then she was telling me about how she is being abused. Yeah so I had a chat with her and then I referred her to the social worker. The social worker went to her place, to where they were living and there was a commotion there. I think he might have assaulted her again. Yeah yeah, the husband assaulted his wife, I think in front of the social worker and then the police were involved so he was put in jail. And I haven't seen him since. No, not even her as well, as a patient so. Sometimes you just worry about how much you can get involved you know? Because sometimes I feel like instead of making things better we might be making things worse for that patient and for the victims especially.

Maintaining those boundaries protects his own safety. 'It's something I have to consider now, you know, because if you upset people and work out their relationship they get upset, they kind of see you as a scapegoat as well'. In the future Mark would make sure each partner sees a different doctor. It is very hard to give counselling to both partners, but facilitating the separation is also difficult due to the relationship with both partners. Mark believes most of the time a patient just wants to be listened to and that is enough. 'Sometimes they just come in just to have a cry you know, just to cry and then they feel better after that and then they go home'. If he referred them they would have to tell their story to someone else which increases the likelihood of confidentiality being breached.

Mark is aware of the issues people experiencing IPV face, how difficult it is for them to make change and how that influences his ability to help, reflected in his *responsiveness*. He is willing to listen and provide options, but experience tells him it is best to refer people on to support services. Mark is also aware of how outcomes can be uncontrollable, which generates doubt in best course of action.

She came in [for a medical certificate] because she had been assaulted by her partner, [this was] about five years ago. Basically, what I did was just sit with her and listen to her story and try and provide moral support and make sure that she's not depressed or want to harm herself, things like this, and that she is in a safe environment. I advise her to go to women's refuge, but she wasn't keen to do that, but at least she was keen to attend the counselling at women's refuge so I did a referral for, to be seen by them, the counsellor there. [...] I feel like I was able to help her, but somehow I felt she was more interested in the medical certificate than getting help herself. I think one

reason is because she probably still likes the partner, the person who assaulted her and she has never pressed charges for 25 years. [...] Hopefully she will get the counselling from the women's refuge, but she's going back to live with her partner again, so probably there's a risk of repeat assault for her. I'm not too sure where else she can go? She doesn't have any other places to, any family member that can support her [edited for confidentiality].

Despite his awareness of the dynamics of IPV, Mark's past experience, coupled with the environment of Whānau Oranga and limited response options constrains his *responsiveness*.

### **Tina, administrator.**

Tina's *response* discourse 'every patient is going to be different' is informed by her *respond* stance that 'you have to show empathy and help the patient'. Tina believes that patient behaviour is a product of many factors which lie outside of their control. For example, she says displays of angry behaviour at the clinic is due to their complex health needs and disability. She strongly believes that Whānau Oranga must show care to all patients, especially children, even if they walk-in without an appointment. She describes administration as a hard job as patients may owe money, health care costs may increase, and people do not take responsibility for their health. Although it can be frustrating she believes that you must show patients empathy as we do not know what is happening in their life.

This *respond* stance informs her *response* discourse that 'every patient is going to be different'. A key way she helps patients is by asking questions. 'It's really about finding out, talking asking questions [...] find out what they need because a lot of the time they don't even need to see the doctor'. Triaging patients on the phone streamlines patient flow in the practice. She says there is always appointments with the nurse, and if it is a major issue they will get to see the doctor.

Tina's *respond* stance and *response* generates *responsiveness*, but not directly for IPV. For example, she will use her own agency to work around practice barriers to help patients get access to care, especially for children. 'Why should we direct them to [after hours clinic] when I've got four doctors here you know? I'm really quite staunch about that.' Although she assumes IPV would 'probably definitely' be a problem within their patient population, she is uncertain about whether they address it at Whānau Oranga. She attributes this to not being privy to the information shared in the consultation. However, her *respond* stance guides her *responsiveness* 'I mean I would like to think we're obviously steering everybody in the right direction'. She describes the practice as being part of a community, but the people within community services are not well known. This can challenge her *responsiveness* as she must be knowledgeable about how things work, such as referral pathways. Tina's *respond* stance and *response* discourse guide her to work with management to 'make up our own groove' navigating different referral pathways. Although not in direct relationship to IPV, Tina's *responsiveness* to patients is generated through a compassionate *respond* stance and equitable *response* discourse.

### **Tania, nurse and Mere, social worker.**

Tania and Mere share a *response* discourse of 'it is different for us being Māori'. This stems from a belief that the current resources available 'don't change people's situation', their *respond* stance. The socio-economic circumstances of Māori, 'the realities that whānau live within', are understood as being part of the problem of IPV. They describe these realities as having a 'domino effect' and is 'the norm' for the clients they work with. Tania and Mere strongly feel that without changing the 'realities' that whānau live within, IPV cannot be addressed. They believe the resources available do not reflect the complexity or the severity of IPV for the whānau they work with.

It's a weekly, monthly thing of dodging, or just making the best of a crap situation. So it comes down to that [...] there's either violence, or there's death. Violence they can navigate, they can live with, they can work with. When you're gone, who's gonna look after your children? That's the severity of some of our whānau.

It's not just *The Violence* [...] [it] is only one other thing that they deal with, apart from hungry children, or a roof over their head. You know if it's a good day in that area, it's a crap day in another area, so it's not in isolation' [original emphasis].

Tania believes the idea someone can put their hand up, ask and receive help is a fallacy for the people she works with. It is different for Māori because there is nowhere else for them to go. Mere provides an example of trying to support a woman being stalked for sex by a gang member. Tania and Mere say she has nowhere to go because (a) the victim does not want to notify the police for fear of retaliation (b) the victim has family in the area, 'you know how Facebook is, everybody knows where everybody is, everyone knows what people are doing so there's actually nowhere for them to go without somebody knowing or telling somebody else' and (c) the victim does not want to go to women's refuge 'because everyone knows where the refuges are'. Having nowhere to go problematises responding to IPV as finding a place of safety is the most important thing.

You know we have the extremes of ones that are once gang associated, um and safety plans being put into place so that if he leaves the house, somebody can actually go in and remove her and that is actually quite common, and that, but the gangs have their networks everywhere not only here but also in Aussie, so even if she was to go to Aussie, they will find her there.

Their respond stance calls attention to the deficits of current resources. These resources do not change the situation and can make people feel like more of a victim, reinforcing the negative cycle the person is stuck within. For example, when the police attend:

Oh, look you know [she will say] "he works hard, and I was nagging, and I was doing this and I was doing that, so it's my fault my fault my fault." The bastard shouldn't have hit her [...] 'Like anything, you keep telling somebody that they're stupid blah blah blah, they believe it, and they live it.

For the whānau they work with, this negativity makes an effective *response* difficult as the problem becomes getting people to engage and stay engaged. It is about 'getting them to a point where they want to engage, you know, it's getting them there and being there the whole time'. The link between their *respond* stance, *response* and *responsiveness* is demonstrated when Mere says,

...for me, as not only a social worker, but within my own āhua<sup>1</sup> [*respond*], you know, I want to ensure that that family, they know that we're gonna be there. You know, even if you know, a quick text, a quick call [*response*], just to see how they are, and just for them to know that we're still here [*responsiveness*].

Tania and Mere believe that the 'realities' constrain whānau ability to ask for help. 'For our whānau it's just that daily grind of just, just coming up for air, you know. It's a big ask for them to say "please don't do that". If they did ask for help and got 'slapped on the hand', they would not ask again. They also risk the repercussions of the community they live within (e.g. gangs). Being Māori, Tania and Mere understand these realities which influences how they practice.

You know when I walk into a home and there's nothing on the floor and there's no food in the cupboards, I'm not gonna judge them, that's just their life. They don't need to sit there and tell me all the nitty gritty, you know all the little details because I know, I can see it. So I'm able to go in there "hey I'm here to, I'm here for you and baby, I'm here to help you and support your whānau as best as I can."

<sup>1</sup> Āhua denotes the character of the person.

Tania and Mere illustrate how it is different for Māori by calling attention to the culturally inappropriate programmes offered, saying the facilitators do not understand the ‘realities’ of whānau. There are long waiting lists and no interim options, and they often do not have transport to get there. Being Māori, Tania and Mere are part of the whānau, they will always be there for whānau, whereas other providers come and go with the funding tide. It is different because they are the tangata whenua<sup>2</sup> of the rohe. Tania and Mere can use whānau relationships to generate accountability for perpetrators actions and be upfront with whānau.

I think a big thing is that we are tangata whenua of this rohe so, and there again because we know the people, even though we know that they’re perpetrators, they know that we know that. You know? That’s a big thing too. [...] I know a few perpetrators that are still standing, and we will just keep challenging them.

Tania and Mere both see how current efforts do not change the reality of the whānau they work with making the problem different for Māori. This *respond* stance and *response* discourse influences their *responsiveness* as they change their practice to reflect this. For example, Mere uses her own agency to be there for clients, even if her engagement with them had formally ended.

Sometimes it’s best to stay engaged with them just to keep them safe, as opposed to pulling out the big guns and they get lost, they go underground, and you can’t find them [with their kids] yeah. Yeah and that makes it even more dangerous because they won’t call the cops.

Tania works to provide whānau options.

What I can do is put into place, because if I know that she’s gonna run, if I know they’re gonna hide, it’s where will you be safe, where can you go to, and that’s all I can do, you know, is try and help to identify those safety areas for her, because sometimes when you’re in it you can’t see past it, and sometimes what’s needed is somebody on the outside saying “hey over here” [laughs], you know “come over here” or whether it be five minutes, ten minutes, or just a breather for them just to, to look outside of their own little box, it gives them an option, it gives them that little glimmer of hope that if they do take it, it might change.

Interestingly, both Tania and Mere did not recognise their own work as being a culturally appropriate ‘resource’ that helps create change for whānau. Their strong view of inappropriate resources for Māori motivates them to practice differently to ensure the safety of their whānau. The recognition of the system deficits and inequities for Māori increases their individual *responsiveness* but they are constrained by services and systems which do not recognise the complexity and severity of IPV for whānau.

### **Mary, practice manager.**

Mary’s *response* discourse ‘we’ve only got so much capacity’ is influenced by a *respond* stance that the clinic is not adequately resourced to manage the mix of health and social problems they encounter. She describes the patient population as ‘high needs’ and a local context where general practitioners struggle within a poor fiscal sector. For example, she says it is difficult to get people back to the practice for follow-up. For children immunisations; ‘...it’s so fluid out there of where that child is ... between two sets of grandparents and aunties and uncles and that. It’s very hard to catch that child in one place.’ She says because the practice is ‘cheap’ they get a lot of people with mental health and substance abuse and threatening behaviour.

This *respond* stance supports her *response* discourse that the practice only has so much capacity. She argues community agencies are better placed to manage follow-up ‘because the clinic

<sup>2</sup> Tangata whenua are the people of the rohe, the land or region where they are born.



doesn't have the resources to really do it.' She cites capacity issues of time pressure, the 15-minute consult period and the number of patients coming through. Mary views access to community services as a great advantage over other general practices. However, the practice is still struggling as they do not utilize or connect to the services as much as they could. She also sees this as an issue for the wider health system asking whether the 'many' community support groups are reaching the right people and 'if they're not, why aren't they?'

Does general practice even know about them [community services]? A lot of them will probably be patients that are discharged from hospital secondary services into them [community services]. But I'm not sure if general practice is fully aware of, and whether they do have access to into them.

She argues the constant turnover of community services means GPs cannot remember what is current, which is why a better connection with the onsite community services is needed.

Mary's *respond* stance (inadequately resourced), means she places responsibility on the patient to disclose to the GP. 'I think with a lot of the family violence, they will hide it, and it depends on that relationship between the GP and the patient whether that patient's going to be responsive to even mention it.' She does acknowledge training is needed to see the signs and signals if the patient does not tell them directly. However, Whānau Oranga is unable to host their own training due to their small size and they are blocked from accessing training hosted by Primary Health Organisations. Further, Mary suggests that trainings are not always general practice specific. She provides an example of GP mandatory reporting requirements.

...there were bits of resistance from general practice because reporting families and that to [child protection services], if the GP was concerned about the child, they had to make sure that the mother thought that it was a safe environment at the general practice to bring the child back, because the GP didn't want to lose them, they needed them to come back. They kind of thought if they stepped too heavily the mother would disappear with the child and they wouldn't get them back, or see them again, and they thought that this will put the child more at risk. [...] When the GP is concerned and wants them to come back and follow-up with the child, from experience mothers do disappear. They're gone, and they won't go back. So yeah, I could see the tug-of-war going on in their heads [...].

Mary's Triple R Pathway reflects her management position, calling attention to wider system interactions which influence the ability of health professional *responsiveness* at the clinical level.

Moana, **Primary Health Organisation** manager.

Moana's *response* discourse 'It's not a priority' is informed by a *respond* stance which seeks to redefine health within a kaupapa Māori<sup>3</sup> framework. She strongly believes that the health care model they are funded for misaligns with the model the Primary Health Organisation is working to deliver. The Primary Health Organisation is trying to change 'the hearts and minds of frontline workers' to move from a 'sickness model into a wellness model'. Under the 'sickness' model, IPV would need to be set as a funded priority for frontline professionals to address it. A focus on achieving the funded health priorities means there is not enough resource or agency to address IPV. Moana believes the current model constrains the way the Primary Health Organisation would like to practice.

We're involved in paradigm shift to move people from a pathological one to a wellness model, whilst working in the health system which is an illness model, so there is a paradox in that, that we have to constantly try and manage.

<sup>3</sup> Kaupapa Māori is a philosophy which incorporates the knowledge, skills, attitudes and values of the Māori world.

She acknowledges IPV is a challenge that must be overcome to be 'mauri ora' (individual good health) but that it is not a priority for families. She believes families are more interested in 'survival', such as having a school uniform or a place to live. Moana says being poor shapes the way people think, as well as exacerbating IPV.

Moana's *respond* stance (redefining health) shapes her *response* discourse that IPV is not a priority for the Primary Health Organisation. She acknowledges that IPV is often flagged as an issue in monitoring and management reports, but it is considered a 'backdrop' to challenges in health service delivery. The Primary Health Organisation is concerned about the 'welfare of children and families and safety' where IPV is one important part. The contradictory nature of this aim illustrates the paradox the Primary Health Organisation faces. Different organisational models within the Primary Health Organisation further complicates the shift to a 'wellness' model. Moana cites the challenges as (a) trying to move to an integrated approach with community services, but being challenged by the requirement to report individually (b) being 'both true to our vision and contract compliant [...] requires immense creativity and commitment' and (c) different philosophical visions across affiliated organisations (e.g. Whānau Oranga) making alignment challenging. Nevertheless, she believes adequate organisational structures are in place to deal with arising issues such as IPV. 'If intimate partner violence became a clinical risk issue then that would be brought to the clinical governance board'.

Moana's *respond* stance and *response* discourse generates low *responsiveness* specific to IPV. Recognising this, she questions whether the Primary Health Organisation takes responsibility for IPV very well. She says frontline professionals lack the skills to routinely enquire about IPV and there is no adequate training. She deflects attention from the Primary Health Organisation by questioning whether health professionals should be trained to 'alert' or whether there should be a public campaign to help families ask for help. She says current messages on family violence either are not there or are confused.

So if they speak out where do they go to, [...] what are the practical resources that they can have to protect them for the moment, when you've got a housing issue you know? Do you move out? I mean how do you learn to navigate that space if you want to stay in the relationship but stop the intimate partner violence [...] How do you navigate it in a way that's going to ensure that you still have a relationship with the father of your children? How do you do that if you demonise that person [...] fracturing the relationship that may in fact escalate the situation and certainly fractures the relationship between the children and the parents.

She believes health care is 'a point of call', but 'to tie it mostly into health is an unrealistic situation' because we have a whole 'system which is complicit with maintaining intimate partner violence' so having a response in one place 'is not a sensible method of doing it'. To be responsive, we must change how we approach an IPV response, tying back to her *respond* stance. 'So that there is always a solution which is mana enhancing, for all, that safety and integrity are maintained, and choices are available.' Moana's Triple R Pathway calls attention to wider system interactions influencing clinical interactions. A focus on overall whānau wellbeing obscures responding to IPV. It is not a 'clinical risk issue' but just one challenge amongst many they must address. Whānau Oranga frontline professional voices expressing the need to respond effectively to IPV is not heard at the Primary Health Organisation level.

## 1.2 Family Care Practice

Table 2. Participant *respond* stance and *response* discourses

Participant	<i>Respond</i>	<i>Response</i>
Anna, General Practitioner	It's a big problem unrecognised for its importance	I just need to do it
Donna, Practice Nurse	It was really easy in the emergency department	We need to have a process



Sally, Practice Manager	We do the best for our patients	It's probably happening anyway
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**Anna, general practitioner.**

Anna's *response* discourse 'I just need to do it', derives from recognition that family violence is a big problem unrecognised for its importance, her *respond* stance. She believes a health care visit may be the only opportunity for intervention. Her work in sexual health opened her eyes to violence occurring within families and whānau. Anna claims family violence is not discussed enough in health care, believing health professionals find it difficult to discuss because they have not been trained or educated to deal with it and feel like they would not respond well. 'I don't think I've ever had any training from anyone regarding it and that's so important.' She describes a situation which occurred when she first qualified as a doctor.

It's something I definitely felt like I wasn't well-trained for. I remember seeing a case, um, well it was a little girl [...] I remember seeing her in ED and she had this vaginal discharge and she was four. And I didn't feel happy screening the mother about possible abuse [...] and I felt completely out of my comfort zone and I went and asked the ED consultant to go to see her and then she was like "oh no, you do it and see how you get on". Well I just felt completely useless, I didn't think I was doing well, I didn't want to offend her but I felt like I wasn't doing a good job and I was worried about was I doing an adequate job and I asked Paediatrics to come and see her as well and they refused, they said they didn't need to, just for us to do a swab and that was it. It came back as gonorrhoea, and she was [being abused]. Then it obviously all got dealt with and everyone was involved. I remember feeling that I just felt terrible, like I didn't really feel that I had the tools to question this lady about her four year-old child when clearly, and she did, as it turned out, had no idea that anything was going on, no clue. And um, I think it is just having the tools to ask the questions, the right questions without offence, feeling like you're offending someone [edited].

Anna believes that 'for some people who don't deal with it at all probably it's just a whole other world that just doesn't really become apparent because you don't see it or ask'. It is only when you see victims of violence that you realise how common it is. 'I mean the stories and people you see are just everyday people that you see [...] we must meet on a daily basis.' Anna thinks family violence is often not at the forefront of health professional minds because they are not aware of how much an issue it is, they may not see it regularly, and they have to keep up to date with other health issues. She advocates for increased understanding and awareness to be able to provide effective support straight away which will make 'such a difference to people's lives later on down the track'.

Anna's recognition of family violence as a big and important problem (*respond* stance) leads to her *response* discourse 'I just need to do it'. She believes it should be normalised into practice so it becomes a habit and something she asks about every time. There are a number of barriers to asking. She believes people are concerned about what they need to do, how much time it will involve and what referral resources are available. The prevalence of IPV can also act as a barrier to screening, for fear of a lot of positive responses. She also says people don't realise resources such as a sexual assault service are available and can be utilised for their patients.

I think it's about having the systems in place to um, that you can refer to so you're not feeling left to deal with it on yourself, and feeling completely isolated [...] sometimes you feel like you've got no support from anyone else, and you just don't have the time to spend with people over, well you can keep getting them back and even not charging them, or you know just making phone calls and all the rest of it, but you sometimes just feel so unsupported around issues, when you know it's so important to deal with it and the risks.

Anna recognises the benefit of the established relationship between doctor and patient but acknowledges she does not capitalise on it enough. She realises she must have come into contact with people experiencing IPV without recognising it. Anna believes it is about the timing for people, asking the right questions and providing an environment where they can talk about it.

Ah, I had a lady who had really bad anxiety, terrible terrible anxiety when I was at [practice], um, and I started talking basically about that [abuse] and that all came down to [...] she'd been sexually abused as a child and this was now, you know 20 years down the track and she'd never had any help whatsoever, and but she had terrible anxiety [...] something had triggered it all off again, and she was getting panic attacks and just huge levels of anxiety and it all came, eventually she did talk about that and we got her seen at [sexual assault service] actually and she did brilliantly. [...] but that was 20 years down the track and that was just presenting as mental health and anxiety.

Anna also described a new patient who disclosed sexual assault on the first visit, where she talked about the sexual assault service and the counselling available and referred her on. Nevertheless, for Anna, the open, trusted relationship is key to being responsive, but she acknowledges the uncertainty of the interaction.

I think if you can build up a relationship its helpful for people to disclose things, but maybe sometimes it's easier to disclose things to people you don't know or never met. So, I don't know, I guess one thing works for one and not another maybe, but I don't know.

Anna's *respond* stance, 'it's a big unrecognised issue' and *response* discourse, 'I just need to do it', means she is *responsive* when she encounters violence. However, she feels like she could do it better. For example, Anna feels if she had more training she could be more responsive. She is aware and willing to engage with IPV, but her *responsiveness* is not yet fully realised as it is blocked by other system interactions, such as an absence of dialogue between health professionals on addressing IPV in practice.

### **Donna, nurse practitioner.**

Donna's *response* discourse 'we need to have a process' is informed by a past position addressing family violence in secondary care. She 'saw it all the time' in the emergency department and viewed family violence as an issue for everyone regardless of ethnicity or socio-economic status. She believes implementing processes to respond makes it 'just really easy', her *respond* stance. Donna constantly compares the primary care response with the secondary care response. In primary care there is no process to follow if someone discloses. 'You'd be like ok, what do I do with this information'. In contrast, a process guides you 'this is what happens, this is what you do'. The process should be preceded by health professional education and followed with physical environment resources (e.g. posters, leaflets). Donna believes a visit to the GP is an opportunity to access support and ask if they need help, rather than 'not even acknowledge it, [...] particularly if the violence is ongoing'.

Knowing it was really easy respond to IPV in the emergency department heavily shapes her *response* discourse 'we need to have a process'. The absence of a process in primary care means there is no awareness of the issue. This starkly contrasted with her experience in secondary care where it was something she looked for because of the process in place.

I think it's not felt to be important. When I first came here you know having come from that role and I talked to people in the practice about it, people were just like - apathetic about it and so it just slipped under the carpet, whereas to me it was, like it was always high on my radar because we had to do it and it was in your face all the time, and it was your opportunity, [...] that was how it was put to us you know "it's your opportunity to make a difference", "you can ask and a person trusts you" and

blah blah blah. Whereas here no one was interested really, not that they weren't interested, it wasn't high on their radar.

The lack of attention to family violence was a surprise to Donna when she began work at Family Care Practice.

Whereas here, maybe you know it's not prevalent, or it is prevalent, but people don't talk about it. If it was happening every day or every week then you know probably the practice would say 'oh ok well we actually need to do something about it'. Maybe it is happening every week and people just aren't talking about it. Yeah. I think so. Yeah.

She attributes the difference to primary care not being provided the funding needed to put systems and processes in place, whereas hospitals are. This argument extends to patients having to pay to see their doctor or nurse.

So maybe it's because you have to pay to come and see your doctor or your nurse, [...] maybe that is why people don't come, or they don't discuss it [...] "I need to see the doctor, so I'm gonna talk to them about my sore throat but actually I don't want to have to pay for an extended consultation or whatever to talk my family violence" so they don't. [...] That might be one of the areas, I don't know.

Following Donna's *respond* stance and *response* discourse, Donna credits her *responsiveness* to her prior experience and training in secondary care. As a nurse practitioner she is unsure how she would access IPV information and resources. 'Not off the top of my head can I think I know exactly where to go for that'. Yet interestingly, Donna describes a clinical interaction where she was responsive to a historical sexual assault disclosure, despite the lack of processes in place. She was unsure what prompted the disclosure.

Oh, probably a question of you know would you like some STI swabs? Yeah yeah probably that was it. Or maybe just the simple fact that they were having a cervical smear, the procedure itself [...] that associated to them about the sexual assault. Maybe? I don't know. If they'd just come in for some other blood pressure or something it might not have triggered that and also we're in a locked room? So maybe they felt that they could talk about it? I don't know what it was that [...] encouraged her to talk about it, I don't know.

Following the disclosure, Donna organised the patient to see a GP and access the sexual assault service. The GP, who was not part of Donna's clinical team, then asked Donna to follow up with the patient because of the established relationship. The assault was also mentioned during following visits with Donna for other health care issues. Although she was *responsive*, Donna's *respond* stance and *response* discourse still called attention to the lack of formal process.

[It was] just something that we did. There was no process in it as such, yeah we just did it. Yeah but there was no process to follow like this is what you need to do, you need to contact them a week later, a month later, whatever, nothing. [...] Whereas if it had happened in the emergency department there would have been a process that I would have had to have reported this and who I would have had to report it to. But actually I could have just talked to that girl and she disclosed it to me and done nothing, but I felt, probably because of my experience, that this needed to be, you know so I talked to her about that you need to follow this up, you need to talk to somebody and the best person will be the GP. Yeah. But actually, people may have disclosed things to other people and they haven't followed a process about getting some follow-up.

Donna's *response* discourse and *respond* stance informs her belief that Family Care Practice cannot be responsive to family violence without systems and processes in place. Yet she was able to be responsive to a sexual assault disclosure without processes in place. Donna's pathway obscures how someone can be *responsive* with minimal systems in place. Her education contributed to her *responsiveness*, asking questions, providing access to further care and follow-up. This generated mutual benefit for both Donna and the patient. Recognising how Donna is being *responsive* without processes may shift her *response* discourse, opening new opportunities.

### Sally, practice manager.

Sally's *response* discourse 'it's probably happening anyway' is derived from a solid faith that staff provide the best care for their patients, her *respond* stance. Sally has minimal understanding of IPV, demonstrated by her use of common stereotypes. Not many patients at Family Care Practice would be experiencing IPV because of 'where we are and what our patient base is made up of'. She conceptualises IPV as a one-off event and that the first point of call would be the hospital, not primary care. She modifies this during the interview, realising it may escalate over time and they may talk to their GP or nurse. 'My mind didn't go that far, it was sort of like the initial "call the police"'.

The strong *respond* stance that they provide the best care for their patients, means Sally assumes that 'it's probably happening anyway'. Reflecting her *respond* stance, she believes that the doctors would be aware of how to *respond* and what resources are available. She believes it is the 'doctor's duty' to help them 'leave the relationship' or 'remove them from the situation', though she qualifies this by not knowing what is discussed in consultations. Sally's *response* discourse 'it's probably happening anyway' suggests she believes doctors and nurses should be responding. If they are not, it is because 'probably we're not aware a lot of the time', which contradicts her *respond* stance of providing the best care. She places responsibility of disclosing on the patient, unless there are physical signs such as bruising. 'Unless the person actually says [...] they wouldn't know'.

The contradiction between her *respond* and *response* influences her *responsiveness*. Sally talks about how the practice has had to adapt and change to the changing environment of health care and increasing complexity of patient consultations. She also specifically talks about mental health being a big part of their practice but does not connect this with IPV impact. Sally says people experiencing IPV would 'be top priority' for a counselling session, assuming they disclose or are identified. Changing the way they work is also constrained by the business nature of general practice.

We're having to sort of think outside of the square and tap into the funding that the PHO [Primary Health Organisation] and DHB [District Health Board] offer and try and maximise the patient care as well as make it profitable [...] we want to do great things for our patients, but someone's got to pay.

Practice funds are influenced by their patient register, technology (e.g. a MedTech licence) and the huge cost of business. Sally says the practice is shifting into a 'user pays' mentality with increased costs for patients. Although hospital care is free 'a lot of them don't like that, they want to come here to the practice, so that's their choice and they have to pay'. As Sally believes responding to family violence is part of good care, her *respond* stance contradicts her *response* discourse 'it's probably happening anyway'. For Sally, the lack of recognition directly leads to no *responsiveness*.

## 1.3 Te Whānau Hauora (The Family Health)

Table 3. Participant *respond* stance and *response* discourses

Participant	Respond	Response
Dave, General Practitioner	IPV is a common social ill which is difficult unearth	I try to ask the question
Hana, Practice Manager	We engage differently with whānau	It just doesn't happen like that

Sue, Primary Health Organisation Manager	The system is broken	It's about that safe space
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### Dave, general practitioner.

Dave's *response* discourse 'I try to ask the question' has emerged from a set of beliefs within his *respond* stance articulating his perception of society and understanding of IPV. He believes IPV is common in his practice, particularly for his patients, and that 'a lot of the stuff [violence] comes from social ills. It's happening in families where there is unemployment and overcrowding.' He believes that IPV 'is difficult issue to unearth', that women find it difficult to talk about, often taking several consultations before making a disclosure. He also feels being a male practitioner is an additional barrier to disclosure. He believes that women 'aren't keen' to use the limited resources available 'because they don't want to lose their home I guess' and that there is little point in reporting the abuse if the woman involved won't 'back it up or follow through with it'.

Dave's participation in the research introduced a relationship between these beliefs and a discourse of a health care *response* to IPV. That is, it wasn't until he participated in the interview that the relationship between IPV as a health issue and a health care *response* to IPV was made. For example, Dave considered that he 'may be the first person to find out about it' and has 'authority' in 'referring and helping a woman [and] treating the consequences of it.' He believes he plays only one part, and all social agencies, police and health settings 'should probably respond' to people who present with either physical or psychological issues 'that have domestic violence at their root'. Dave's beliefs generate a weak *response* discourse as he is unsure what he means by IPV as a health issue. For example, the use of the word 'try' in his *response* discourse indicates doubt in his ability to provide an effective *response*, constraining his *responsiveness*. Dave tries to ask the question, but acknowledges it is only on an 'ad-hoc basis'. He describes 'the guts of it at the moment' as listening to the patients concerns as well as possible, and 'offer solutions in terms of leaving the home' or contacting Police or Refuge in an acute situation. Multiple small stories within Dave's narrative illustrate the doubt he experiences.

The typical thing is a woman who has got depression and anxiety for no obvious cause. You take a history, or she gives causes, and you respond to that as depression with medication and/or counselling. Counselling and/or medication whatever. Then after maybe three, six, months you become aware that actually she's been beaten up or sexually abused or whatever. Boom, then what? I don't think we'd change that! [how you engage] But you'd remain engaged with them as much as you can and keep treating their depression. But you think, 'Well the best way to deal with this is to leave your man, or report him to the Police' or whatever, but if they won't, they won't.

I think the main issue though would be a lack of resources to deal with it. You might be aware of it and not quite know where to go with it beyond the women's refuge, which they already go to, and Police which they're not going to go to. What do you do then?

I guess the problem is if it comes to you from a third party. Another nurse, or another doctor, or indeed a relative. It's hard to know how to respond to that. The woman herself hasn't brought it up, she may not want it brought up. Doing so, although obviously one wants to deal with it, might be counter-productive in terms of the relationship with her and me. So that's a very real challenge and of course the relationship with her partner who may also be a patient of mine.

Although Dave calls attention to things which would help to reduce doubt such as making the question routine, delegating responsibility to other team members, or developing a pathway, doubt of what to do constrains his *responsiveness*. He doesn't ask about IPV because he believes there are a

‘limited number of resources available’ and he is unsure of what he would do if IPV is disclosed. The perception of deficits in resources or knowledge justifies his doubt. For example, ‘there’s no point in screening for anything unless you’ve got a *response* to it’. He says general practice needs more ‘help’ such as specialised counsellors, referral points, knowledge of what other agencies do (e.g. police and refuge), and communication from other health settings about their patients who are experiencing IPV. Dave’s set of beliefs (*respond* stance) generates a weak *response* discourse characterised by doubt which blocks his *responsiveness*.

### Hana, practice manager.

Hana’s *response* discourse ‘it just doesn’t happen like that’ is influenced by a strong *respond* stance that her organisation engages with whānau [extended family] differently to other health care services. She argues a first-line response would be ineffectual as IPV does not present to the hauora in that way. Therefore, responding to IPV is not a specific part of what they do. Instead, she seeks to engage with whānau in ways which open spaces for people to ask for help for anything, including IPV. For Hana, IPV occurs because of problems at home. She says whānau find it difficult to, and are fearful of, asking for help. Instead, the hauora [wellbeing clinic] seeks to intervene in the determinants of IPV. She says, ‘that’s when we kick into okay, there’s all these underlying issues that may have been a build-up of that violence, and it could be that it’s somewhere in there that we could intervene.’

Hana’s *respond* stance significantly influences her *response*. ‘So ideally, we would love them to come to us first, before it all happens, but it just doesn’t happen like that.’ Instead the hauora provide advocacy support for whānau members who present at hospital. They host wananga [seminar discussions] to provide a space for people to say, ‘I need help’. She says, ‘that’s how we are able to capture the core problem which will relate back to home.’ The hauora presents engagement with whānau as a choice; ‘I can only [...] intervene if I’ve been asked to’. Whānau can decide ‘how they want to present to us what’s happened’, they ‘have a choice as to what kind of services they would like’ and ‘how we [hauora] would fit in that picture’. Engagement is with the whole family, recognising suffering affects more than the individual.

Hana’s *response* aligns with the way her organisation engages with whānau (*respond* stance). Her *response*, ‘it doesn’t happen like that’, is continually being reinforced by the *respond* stance, ‘we must engage differently’ and vice versa. Hana describes what it would be like to engage using a public health approach.

But how do you do that, how do you go to a family member ‘Oh how you been? Actually, have you been bashed lately?’ You know, who the hell does that? That’s disrespectful in the first instance. It wouldn’t work here. We wouldn’t do it like that because it’s not part of who we are as a people. [...] Oh! Can you imagine the comebacks ‘Who does she think she is, coming into my home or telling me, and asking me shit like that?’ You know, that’s disrespectful firstly. [...] whānau struggle, especially those being violently aggressive in the home, to come out with that [ask for help] because of fear.

Hana’s *respond* stance and *response* discourse shapes her *responsiveness*. Hana says that although an IPV intervention might first occur in secondary care, it is the hauora that supports the family.

Organisations like myself, we’re not always the first and foremost, the beginning or the end, of any whānau in that situation. [...] We’re different. That’s why we have organisations like [general practice 3], is that we pick up the pieces, pretty much.

She provides an example of the ‘pieces’.

I can take care of the smaller things, like a mother may be feeling low self-esteem in herself again, because she’s been told she’s useless and she’s a dumb bitch. That’s where I can help, just by putting a little health plan together for her, regular exercise, looking at having a couple hours a day, or an hour a day by herself just to reflect.



Being around friends and other positive family members, going for walks up the [mountain]. Those sorts of things we can help [with], making sure she's going to her [doctor] appointments through our shuttle service, making sure the kids are well, looking at their finances, putting a budget together for them. Those are all the little things that we can do as a provider. So they don't think 'Oh is that it, I just have to have counselling.' There's other ways and means of making yourself feel a bit more important. Whether it be the mum or the father.

Hana's *responsiveness* derives from the strong relationship between her *respond* stance and *response* discourse. Her Triple R Pathway has self-organised to be as *responsive* as she can within the interactions she may influence, generating an adaptability to the changing environment. For example, Hana's *responsiveness* is not constrained by low funding. She believes, 'at the end of the day, that funding's only there to help us resource ourselves. It's us that supports the family, we just need that little putea to keep us going. That's really all it is. That's my mindset.' The patterns of relationships between Hana's *respond* stance and *response* discourse generates a balance which provides resilience to the changing environment. Her *respond* stance leaves room to co-evolve alongside whānau. Hana's wide understanding of the complexities involved in responding to IPV as a health issue for whānau initiates *responsive* RRR Pathway, however, she remains constrained by health and social systems which generate fear to ask for help.

#### **Sue, Primary Health Organisation Manager.**

Sue's *response* discourse 'it's about that safe space' is driven by a *respond* stance that the system is broken. She believes people can't ask for help because (a) they don't trust the system and (b) they're scared of the system because it's punitive. 'The system demonises people [...] it's always worst-case scenario'. She believes a lot of people

are really scared, that they will lose their children and they see the immediate loss of their children to the system as worse than the potential loss of life. It's crazy, and I don't quite understand myself, but that's just how it is. They think they can prevent the death of a child, when they can't, they really can't in those sort of situations.

Sue believes that violence is an outlet from the pressures of life, a problem emergent from social determinants. 'Domestic violence is a symptom of people not coping with bad things that are happening in life'. She believes people don't have the right mindset when it comes to health. That people 'don't see health as wellness [...] They don't see health as being healthy, they see health as being sick.' This shapes her *respond* stance, leading to the *response* discourse that people need someone to make the space for change.

She believes it is necessary to 'create a space where they can start taking responsibility for their body'. This involves prevention and allowing people to participate in designing their own solutions.

If people don't think they need help, they can't be helped. I think one of the biggest gaps is that we don't ask people to design their own solutions. I'm not saying that everybody will be able to, I don't think that everybody will be able to, but if we could get them to think about how would you move forward from this, then I think you'd come up with some pretty good things. 'What things can you put in place yourself?' Ultimately, they're gonna have to make the changes. If they've bought into or helped design the changes that they want to make, it makes it more tangible. Instead of just a 'this is what you must do, you must not go back to them and you must not expose the children to him, and you must not drink, and you must not do this.' It is, it's like you're either gonna be punished with someone's fist or punished by the system, it's like far out. I think they have to come up with different solutions. But again, I think it's about that safe space, to be able to disclose and then create the solutions.

Sue's *respond* stance 'the system is broken' constrains her *response* and *responsiveness*. She believes a different approach is needed to change the system but feels unable to achieve that because the system is broken. For example, she claims the current health system focuses on addressing single issues where there are multiple issues involved.

Mental health issues, they don't come by themselves [...] it's very hard to find housing support for people with mental health issues so that leads to another pressure which leads to domestic violence. It's cyclic unfortunately [...] the cycles can't end unless something changes.

Similarly, she believes the current approach to health care limits what they can deliver contractually (i.e. contracts are dependent on District Health Board approval), but they also cannot leave whānau exposed. Sue's *responsiveness* is focused on bridging the gap between the District Health Board, general practice and community.

We are constrained by our own capacity, and our providers. They [general practices] keep telling us 'We want this, and we want that', and we kept saying to them you have to deliver, and a lot of them unfortunately, aren't delivering at the moment. It's actually a thing that's happening across Māori hauora providers [...] We [management committee] don't hear from our people. That's a big problem that we have. We talk to the kaimahi [lead staff member] of every provider. They're the medium.

Sue helps providers to construct 'the story we are trying to tell the District Health Board about your service, your people and your community.' However, she feels challenged by a time delay between receiving reports, sending them to the District Health Board and receiving a response. 'So, if there are issues, immediate issues, how do we pick that up? And how do we bring it to the attention of the District Health Board or Ministry [of health] in real time?' As Sue sees her *responsiveness* being constrained it reinforces her *respond* stance (the system is broken) which shapes her articulation of what a *response* should be (creating safe spaces). Her *respond* stance constrains both her ability to achieve her *response* discourse limiting her *responsiveness*.

## 1.4 First Medical Care

Table 4. Participant *respond* stance and *response* discourses

Participant	<i>Respond</i>	<i>Response</i>
Corina, General Practitioner	IPV is not a problem for my patients because they are well educated and affluent	'I haven't even asked the question'
Layla, Practice Nurse	'New Zealand has got a huge problem'	'It's your responsibility to look after people'
Ruth, Practice Nurse	Family violence isn't well looked after, it's easily missed and there aren't a lot of options	'There's an instinct that something's not quite right'
Mike, Practice Manager	IPV is a human rights violation	We need an effective and consistent process

### Corina, General Practitioner.

Corina's *response* discourse 'I haven't even asked the question' was strongly influenced by her belief that IPV was not a problem for her patients. Her *respond* stance was based on a worldview that IPV was not a high priority for her patients because they are well-educated and affluent. This was

continuously reinforced by her interactions with patients where IPV was almost never seen. Corina viewed IPV as ‘something that doesn’t come across obviously, but it might be a hidden problem’, functioning to obscure IPV as a health issue for Corina. Corina’s participation in the research interview interrupted this feedback loop and she reconsidered her worldview.

Come to think about it, when I think about some of my mental health situations there have been instances where partner violence has been a part of it. I’ve supported the patient through the mental health issues and the violent partner has been discussed, but it’s not an issue anymore, but it’s been a trigger for their mental health issues. So I’ve managed or helped that particular patient through some of the mental health, the depression, the anxiety, and the post-traumatic stress. I guess I’m sort of following up the consequences and the sequela of domestic violence, but are not sort of actively looking for it. I’m seeing the health effects of domestic violence but perhaps not asking a question or picking it up before those health issues develop.

The change in Corina’s *respond* stance shifted her *response* discourse to articulate IPV as an ‘area we are not doing very well in and we should improve’. This new articulation allowed for multiple *response* options to be conceptualised such as normalising the question, establishing a referral process and having knowledge of support agencies. The shifting *response* discourse motivated her *responsiveness* where she called attention to the need to know what to do with the information shared by the patient.

Certainly, at the moment I’d be floundering a little bit I think. I’d say ‘Ok well I know there’s women’s refuge’ but I don’t really know. The thought of getting a social worker, because I don’t do that for many of my patients, that’s unusual for me. I’d be like ‘Well okay right. That’s really important. I don’t want to dismiss it, but what I am I going to do with that information now?’ At this stage I don’t have a clear kind of idea in my mind of where I would go with that information. I’d work it out, as I say, maybe the mental health team would be there, or getting numbers from women’s health, but it would be quite nice to have a better idea. Definitely.

Because Corina would not know what to do if someone disclosed to her, the original *response* discourse ‘I haven’t even asked the question’ is reinforced, influencing her *responsiveness*. For example, Corina fears that her consult will be extended ‘even more’ if she asked about IPV as she would have to figure out what to do within an environment of high expectations, demands, pressures and time constraints. Stepping into an unknown where interaction may lead to many diverse outcomes contributes to the stressful environment she describes. Her *response* discourse is reinforced, constraining her *responsiveness* as well as opportunity to change her *respond* stance.

### **Layla, Practice Nurse.**

Layla’s *response* discourse ‘It’s your responsibility to look after people’ stems from a *respond* stance where ‘New Zealand has got a huge problem’ with family violence, reinforced by the belief the current system is ineffective in breaking the cycle. This *respond* stance morally upholds her *response* as being everyone’s prerogative, modelled in her *responsiveness* by being accessible. Layla describes IPV as being a ‘hidden problem’ where ‘if you don’t ask they won’t give you the answer’. To bring IPV out from ‘hiding’ you must be accessible. This includes being able to effectively facilitate disclosure, ‘tactfully’ asking ‘the question’, looking for inconsistent or repetitive injuries or hearing a hint they give away. You must also be aware of the different dynamics of IPV for different people, such as IPV within low socio-economic groups as opposed to high socio-economic groups.

I asked a lady once, cause she had a couple of broken fingers. She told me how she did it, and I said ‘Are you sure? You know it’s a nasty injury.’ Her husband was a very influential man [...], and the tears welled up and she said ‘No my husband broke them.’ He came into the department and took her off home and she wasn’t allowed

to go to the police. I said ‘Why? Why won’t you go and report him, to stop him?’ She said ‘Because he’ll leave me, and then he’ll take everything, we’ll have nothing.’ So that was her life. We fixed her fingers up and I didn’t see her again. [...] She was a new patient who must have just been at the point that she needed to tell someone. I asked the question. Not that I could do anything about it, but she had told someone, that’s the first step. That’s just the way it is.

Layla’s *response* discourse and *responsiveness* are mutually reinforcing as she believes patients will hide IPV by not saying anything. ‘That’s why I talk to them [...] because they won’t say a thing’. Layla’s nursing team helps her to be accessible by covering her workload, so she can take time to help someone. She believes the accessibility of nurses helps to offset the barrier GPs have of not asking about IPV because of short consultation time.

Honestly, the GPs have quarter hour appointments, they’re booked solid all day, every day. Most of the people going to see the GPs go in for some other reason [medical issue], and honestly, the question is never asked because there isn’t time. GP practices are great if you’re sick, but if you’re sick because of what’s happening at home, let’s face it, it’s not addressed.

Despite the strong moral *respond* stance and motivation to be responsive, Layla’s *responsiveness* is constrained by the perceived inadequacy and ineffectiveness of the current health system response to family violence. Layla doubts her ability to achieve change because of an ineffective system. She cites examples of time constraints and the cost of care (e.g. counselling), which prevent the ability to have necessary conversations and to be *responsive* if disclosed to. Despite the perception that her ability to generate change is constrained by an inadequate health system, Layla’s *respond* stance of New Zealand having a huge problem reinforces her *response* discourse and *responsiveness*.

### Ruth, Practice Nurse.

Ruth’s *response* discourse ‘There’s an instinct that something’s not quite right’ is informed by her *respond* stance that although the health system is improving, family violence is not ‘well looked after’ as a health care issue, it is ‘easily missed’ and ‘there aren’t a lot of options, sadly’. For Ruth you must be educated to ‘see’ it and not ignore it. If it is not seen nothing changes for the patient. This *respond* stance is amplified by her advanced training in sexual health which ‘made you think about things. [...] ‘Oh I never put that two and two together’. For Ruth, education leads to being ‘proactive, rather than trying to ignore it really.’

Ruth’s advanced training equips her with an ‘instinct that something’s not quite right’ which guides her practice with patients.

Even though people think they can hide it quite well, there’s always something that you just think that’s not right, or you need to delve a bit more. When people don’t respond the way you expect them to respond that always gets my alarm bells up. You know if you go to jab a child and they just sit there and they’re not trying to wiggle out of the way and they’re just thinking it’s another thing. If you don’t get the expected response or they don’t cry, they just sit there, that’s when I think something is not quite right, this is not normal, that usually alerts me.

She looks to share the ‘instinct’ by educating other health professionals to amplify *responsiveness* throughout the practice. ‘You try to educate them [GPs] to say look for this or look for that, maybe see this, or maybe a child isn’t responding the way that they should respond’. However, she does encounter barriers. In interaction with colleagues, Ruth faces family violence stereotypes e.g. ‘if you come from say a ‘good area’ they don’t think violence happens in that vicinity, it’s bizarre’. She also notes short consultation times as a barrier. ‘They’ve [GPs] got a short window, so if you see it, you have to see it quickly and you don’t always’. Ruth can also be surprised by an identification or

disclosure that she did not anticipate. It may be unsafe to act on it during the consultation, or the patient may ‘not be ready to have anything happen, that’s a lot actually.’

Ruth’s *respond* stance and *response* discourse strongly influences her *responsiveness* both with patients and with other health professionals.

So just small steps at a time. I’ll just keep saying hello to them if I see them, just get them comfortable, familiar you know? Might be a whole year, might take longer. It depends on the situation really.

‘Small steps’ can include distributing resources such as displaying helpline numbers in toilets and providing brochures. ‘I was quite adamant about just having brochures here. It was a little bit of a battle in the beginning, they got on board eventually. It was my persistence and nagging.’ She advocates all doctors and nurses undertake advanced family violence training to increase awareness within First Medical Care. For example, Ruth suggests that even if services were available to help patients experiencing family violence, not all general practices would be aware of them. Ruth is consistently *responsive*. Her *respond* stance guides the way she thinks about a *response* and how she conducts her nursing practice. Ruth’s pathway is likely to support the emergence of satisfactory outcomes. Instead of avoiding the uncertainty involved in responding to IPV, she engages with it by continuing to be responsive. ‘You just have to do the best you can’, ‘just small steps at a time’.

#### **Mike, practice manager.**

Mike’s *response* discourse ‘we need an effective and consistent process’ is informed by his position as practice manager, tasked with providing effective guidance for clinicians via protocols. Personally, Mike thinks of IPV as a human rights violation, his *respond* stance. He says, ‘we’re talking about freedom of choice here. Choose to smoke, I don’t agree with their choice, but it’s their choice. But when you’re talking about how people are being abused, they’re not choosing that’. Mike would be offended by people who do nothing because they don’t know what to do.

Somebody that is being abused is probably as close to being truly in need is anyone would be. However uncomfortable that might be to witness and to have to deal with, those are the times that you really see the true nature of people I think. Those aren’t the times that people should hide behind “I don’t know what to do so I do nothing”.

Mike believes New Zealand has an ‘out of control domestic violence situation’ and considers IPV to be a ‘high priority’ for health care as it is not uncommon for patients to present to the practice with the effects of IPV. Nevertheless, Mike considers the health system response to IPV as ‘partial’, ‘not well connected, well-advertised, and probably not well enough used’.

It still relies on the person, who’s just had their arm broken by their partner, or been raped by that person, they’ve still got to go home to that person, potentially, or sort themselves out with some other kind of help.

Aligned with his *respond* stance, Mike’s *response* discourse is ‘we need an effective and consistent process’. For Mike, consistency is the key to helping people, generated through policy and protocol. He describes a procedure as the ‘steering document’ which guides a clinical practice. He says, ‘it should just be a question of working through that document really’. Mike does acknowledge that a tension between clinical autonomy and prescriptiveness can challenge consistency and some variation will be involved ‘at what point you look to make a referral isn’t so clear’. Nevertheless, it is his role to make the protocol as effective as possible ‘because that’s where they’re going to turn to’ when they encounter IPV.

Mike’s *respond* stance and *response* discourse does not directly result in *responsiveness*. Although IPV is clearly an issue for Mike, there was no policy or protocol informing clinicians how to respond. He described the practice as focussed on government targets and patient clinical needs. Therefore, he believed a government mandate would be needed to initiate a health system response

because ‘when there’s no choice, we find a way, we always do’. The disconnection between Mike’s *response* discourse and *respond* stance negatively impacts his *responsiveness*. Whether Mike recognises IPV as a clinical need or not, the influence of top down directives, or lack of, will direct his practice.