Early intervention in health settings with men who use violence in relationships

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• Recent research should include men in efforts to prevent VAW (e.g. Flood)
• In Australia, the National Plan to Reduce Violence Against Women & Children highlights early intervention with perpetrators as essential
• BUT little conclusive evidence around how to do this effectively
• Intervention with male perpetrators is primarily through ‘batterer intervention programs’ / ‘men’s behaviour change programs’ / fathering programs
• Men typically are self-referred, partner-referred or court mandated
• Studies suggest court-mandated not very effective at improving outcomes (e.g. Feder & Wilson 2005)
• But men may not self-refer / partner will not refer
• How do we get men to seek help?
• The WHO has identified the critical role of primary care in responding to IPV
• General practice in particular could intervene & respond early → they see the whole family
• Evidence for GP key role in responding to women (Hegarty et al 2013; Feder et al 2006)
• Studies suggest the GP is often a source of help-seeking for male perpetrators (Hester & Westmarland 2006; Mihorean 2005)
• Men → want to be asked about IPV by GP (Morgan et al 2014)
• One study suggested that ~17% of a male primary care sample had perpetrated violence (Oriel et al 1998)
• In a UK survey, 16% of men self-identified as perpetrators (Westmarland et al 2004)
• Generally, however, the majority of perpetrators are not identified in health settings (Sugg 1999)
• There is little guidance for health practitioners on how to respond to perpetrators if identified
Background

Primary care patients presenting symptoms:

• Depression, stress, suicidal ideation;
• Alcohol or drug (licit or illicit) abuse;
• Anger problems;
• Relationship problems and recent separation. (Taft, 2004)

As well as:

• Low self-esteem, anxiety (Gerlock 1999)
• Increased use of services (Coben & Friedman 2002)
• We are working to develop ways to intervene early in primary care settings with men who use violence in relationships

• Interviews/focus groups with men attending MBCPs + interviews with GPs
  – How should GPs raise the issue of violence with men?
  – How should GPs respond if men disclose perpetration?
  – How can GPs get men to seek help?
“A lot of blokes said they wouldn't come to a place like this (MBCP) voluntarily and if maybe they can talk to a doctor and start things off, well that might get him much earlier.”
“Knowledge is not enough. It's like alcoholism. I know you can't drink. Drinking kills you at a certain level. I'm well aware of that. I'm well aware of what it does to you. I've been doing it 30 years. It's not enough to stop you. What is the answer? I don't know.”
• What interventions are effective at improving outcomes for male perpetrators and/or victims of IPV in health settings?
• A way of starting to think about the issues
• The evidence base is seriously lacking!
• Key criteria: Interventions with pre/post evaluation component, in a health setting, that address men as victims or perpetrators

• 1° outcomes: ↓ violence, ↑ mental health for perpetrators or victims, ↓ intervention orders or police reports

• 2 outcomes: ↑ identification & referral, ↑ self-efficacy, ↓ alcohol/drug use
• Most literature focuses on effectiveness of group therapy / counselling / interventions
• Studies in health settings mostly around prevalence NOT intervention
• Some studies investigating screening
• Practitioner attitudes/knowledge towards male perpetrators/victims
Preliminary Findings

- HIV clinic (1)
- Dentist/oral maxillofacial surgery (1)
- Mental Health (2)
- Drug & Alcohol (4)
- Antenatal clinic (1)
- Emergency Department (1)
- Primary Care (2)
Conclusion

• These results are only preliminary
• Full screening and cross-checking of studies still needs to be undertaken
• Quality of some studies questionable
• Clear that there is very little quality evidence for effectiveness of interventions in health settings for male perpetrators