Transforming the Health system: Voices of survivors and practitioners using qualitative meta syntheses

Kelsey Hegarty and Jane Koziol-McLain on behalf of:

LAURA TARZIA
JACQUI CAMERON
EVIE KORAB-CHANDLER
RENEE FIOLET
KAREN GLOVER
MINERVA KYEI-ONANJERI
MOHAJER HAMEED
NAOMI HUDSPETH

GEMMA MCKIBBIN
SURRIYA BALOCH
MEGAN BOHREN
DAVID GALLANT
LEESA HOOKER
JENNY CHAPMAN
JO WATSON
REBECCA ROBERTSON

JO SPANGARO
JEANETTE WALSH
RHIAN PARKER
GENE FEDER
CLAUDIA GARCIA-MORENO
LORNA O’DOHERTY
MOLLY WELLINGTON
Individual survivor level

IDENTIFICATION- EVIE KORAB-CHANDLER
RESPONSE- LAURA TARZIA
INDIGENOUS MODEL- RENEE FIOLET
Women’s experiences and expectations of intimate partner abuse identification in healthcare settings: a qualitative evidence synthesis

Evangelica Korab-Chandler,1 Minerva Kyei-Onanjiri,1 Jacqueline Cameron 2,1, Kelsey Hegarty,1,3 Laura Tarzia 1,3

ABSTRACT
Objectives To explore women’s experiences and expectations of intimate partner abuse (IPA) disclosure and identification in healthcare settings, focusing on the process of disclosure/identification rather than the healthcare responses that come afterwards.

Design Systematic review and meta-synthesis of qualitative studies

Data sources Relevant studies were sourced by using keywords to search the databases MEDLINE, EMBASE, CINAHL, PsycINFO, SocINDEX and ASSIA in September 2021.

Eligibility criteria Studies needed to focus on women’s views about IPA disclosure and identification in healthcare settings, use qualitative methods and have been published in the last 5 years.

Data extraction and synthesis Relevant data were extracted into a customised template. The Critical Appraisal Skills Programme checklist for qualitative research was used to assess the methodological quality of included studies. A thematic synthesis approach was applied to the data, and confidence in the findings was appraised using The Confidence in the Evidence from Reviews of Qualitative Research methods.

STRENGTHS AND LIMITATIONS OF THIS STUDY
→ This study used an extensive search strategy and well-defined study selection criteria.
→ Systematic, transparent methods were used to extract data, appraise the quality of included papers and assess confidence in the findings.
→ Multiple reviewers were engaged at each stage in the research process, some highly experienced in conducting systematic reviews.
→ A limitation of this study is the lack of data relating to the experiences of women in marginalised groups.
→ There are some concerns regarding the utility of quality appraisal techniques for qualitative research.

partner that causes psychological, physical or sexual harm—is a serious public health and human rights issue. It is estimated to affect almost one-third of women worldwide and is linked to a range of serious short and long-term health consequences. These include...
Expectations of Identification

Provide universal education suggesting that all women be given information to understand intimate partner abuse to facilitate disclosure.

Create a safe and supportive environment for disclosure emphasised need for the HCP to demonstrate care and confidentiality in their approach.

It’s about how you ask highlighting the importance of fostering trust and rapport when enquiring about intimate partner abuse.
Women’s experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis

Laura Tarzia, Meghan A Bohren, Jacqui Cameron, Claudia Garcia-Moreno, Lorna O’Doherty, Renee Fiolet, Leesa Hooker, Molly Wellington, Rhian Parker, Jane Koziol-McLain, Gene Feder, Kelsey Hegarty

ABSTRACT

Objective To identity and synthesise the experiences and expectations of women victim/survivors of intimate partner abuse (IPA) following disclosure to a healthcare provider (HCP).

Methods The databases MEDLINE, Embase, CINAHL, PsychINFO, SocINDEX, ASSIA and the Cochrane Library were searched in February 2020. Included studies needed to focus on women’s experiences with and expectations of HCPs after disclosure of IPA. We considered primary studies using qualitative methods for both data collection and analysis published since 2004. Studies conducted in any type of healthcare setting, were included. The quality of individual studies was assessed using an adaptation of the Critical Appraisal Skills Programme checklist for qualitative studies. The confidence in the overall evidence base was determined using Grading of Recommendations, Assessment, Development and Evaluations (GRADE)—Confidence in the Evidence from Reviews of Qualitative Research methods. Thematic synthesis was used for analysis.

Results Thirty-one papers describing 30 studies were included in the final review. These were conducted in a range of health settings, predominantly in the USA and other high-income countries. All studies were in English. Four main themes were developed through the analysis, describing women’s experiences and expectations of HCPs: (1) connection through kindness and care; (2) see the evil, hear the evil, speak the evil; (3) more than just listen: and (4) plant the right seed. If these key expectations were absent from care, it resulted in a range of negative emotional impacts for women.

Strengths and limitations of this study

- This review synthesises and reinterprets rich qualitative data from a range of health settings.
- It used a comprehensive search strategy and robust methods for quality appraisal, analysis and interpretation.
- A multidisciplinary group of reviewers were involved in the meta-analysis.
- A limitation is that few studies were found from low-income or middle-income countries or representing the voices of marginalised communities.
- The use of quality appraisal tools in the context of qualitative research is disputed.

INTRODUCTION

Intimate partner abuse (IPA) is a violation of human rights that damages health and demands a response from clinicians globally. Characterised as any behaviour by an intimate partner that causes physical, psychological or sexual harm, it is associated with a range of serious physical and mental health conditions that can last for many years after the relationship has ended. These include chronic pain, gynaecological problems, sexually transmitted infections and unwanted pregnancies, anxiety, depression, post-traumatic stress disorder and suicidal thoughts.
Expectations of Response

Connection through kindness and care

See the evil, hear the evil, speak the evil

Do more than just listen

Plant the right seed
WHAT

HOW

Choice & control
Action & advocacy
Recognition & understanding
Emotional connection
Indigenous People’s Experiences and Expectations of Health Care Professionals When Accessing Care for Family Violence: A Qualitative Evidence Synthesis

Renee Fiolet 1, 2, Jacqui Cameron 1, Laura Tarzia 1, 2, David Gallant 1, Mohajer Hameed 1, Leesa Hooker 3, Jane Koziol-McLain 4, Karen Glover 5, Joanne Spangaro 6, and Kelsey Hegarty 1, 2

Abstract
Although many Indigenous peoples demonstrate resilience and strength despite the ongoing impact colonization has on their peoples, evidence suggests poor experiences and expectations of health care professionals and access to health care. Health care professionals play an essential role in responding to family violence (FV), yet there is a paucity of evidence detailing Indigenous people’s experiences and expectations of health care professionals in the context of FV. Using a meta-synthesis of qualitative studies, this article aims to address the following research question: What are Indigenous people’s experiences and expectations of health care professionals when experiencing FV? The inclusion criteria comprised a qualitative study design, Indigenous voices, and a focus on expectations and experiences of health care professionals when FV is experienced. Reviewers independently screened article abstracts, and the findings from included papers were subject to a thematic analysis. Six studies were included in the final meta-synthesis representing studies from Australia, the Americas, and New Zealand. Three themes were identified. Health care professionals need to center the Indigenous person in the care they provide and demonstrate cultural awareness of how history and culture influence an individual’s care requirements. Health care professionals also need to ensure they are connecting for trust with the Indigenous person, by slowly developing a rapport, yarning, and investing in the relationship. Finally, Indigenous peoples want their health care professional to work on strengthening safety from culturally inappropriate care, institutional control, and potential lack of confidentiality associated with tight-knit communities.

Keywords
cultural contexts, family violence, intergenerational transmission of trauma, family issues and mediators, Indigenous health...
Indigenous health care model for peoples experiencing family violence (6 studies)
Practitioner level:

PERSONAL BARRIERS- JACQUI CAMERON
STRUCTURAL BARRIERS- NAOMI HUDSPETH
READINESS- GEMMA MCKIBBON
Personal barriers to addressing intimate partner abuse: a qualitative meta-synthesis of healthcare practitioners’ experiences

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Abstract

Background: Healthcare practitioners (HCPs) play a crucial role in recognising, responding to, and supporting female patients experiencing intimate partner abuse (IPA). However, research consistently identifies barriers they perceive prevent them from doing this work effectively. These barriers can be system-based (e.g. lack of time or training) or personal/individual. This review of qualitative evidence aims to synthesise the personal barriers that impact HCPs’ responses to IPA.

Methods: Five databases were searched in March 2020. Studies needed to utilise qualitative methods for both data collection and analysis and be published between 2010 and 2020 in order to qualify for inclusion; however, we considered any type of healthcare setting in any country. Article screening, data extraction and methodological appraisal using a modified version of the Critical Appraisal Skills Program checklist for qualitative studies were undertaken by at least two independent reviewers. Data analysis drew on Thomas and Harden’s thematic synthesis approach.

Results: Twenty-nine studies conducted in 20 countries informed the final review. A variety of HCPs and settings were represented. Three themes were developed that describe the personal barriers experienced by HCPs: I can’t interfere (which describes the belief that IPA is a “private matter” and HCPs’ fears of causing harm by intervening); I don’t have control (highlighting HCPs’ frustration when women do not follow their advice); and I won’t take responsibility (which illuminates beliefs that addressing IPA should be someone else’s job).

Conclusion: This review highlights the need for training to address personal issues in addition to structural or organisational barriers. Education and training for HCPs needs to: encourage reflection on their own values to reinforce their commitment to addressing IPA; teach HCPs to relinquish the need to control outcomes so that they can adopt an advocacy approach; and support HCPs’ trust in the critical role they can play in responding. Future research should explore effective ways to do this within the context of complex healthcare organisations.

Keywords: Intimate partner violence, Health practitioners, Qualitative meta-synthesis, Barriers
Personal Barriers Themes

I can’t interfere
describes the belief that IPA is a “private matter” and HCPs’ fears of causing harm by intervening

I don’t have control
highlighting HCPs’ frustration when women do not follow their advice

I won’t take responsibility
illuminates beliefs that addressing intimate partner abuse should be someone else’s job
Health practitioners’ perceptions of structural barriers to the identification of intimate partner abuse: a qualitative meta-synthesis

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Abstract

**Background:** Health care practitioners (HCPs) play a critical role in identifying and responding to intimate partner abuse (IPA). Despite this, studies consistently demonstrate a range of barriers that prevent HCPs from effectively identifying and responding to IPA. These barriers can occur at the individual level or at a broader systems or organisational level. In this article, we report the findings of a meta-synthesis of qualitative studies focused on HCPs’ perceptions of the structural or organisational barriers to IPA identification.

**Methods:** Seven databases were searched to identify English-language studies published between 2012 and 2020 that used qualitative methods to explore the perspectives of HCPs in relation to structural or organisational barriers to identifying IPA. Two reviewers independently screened the articles. Findings from the included studies were analysed using Thomas and Harden’s method of using a thematic synthesis and critiqued using the Critical Appraisal Skills Program tool for qualitative studies and the methodological component of the GRADE-CERQual.

**Results:** Forty-three studies conducted in 22 countries informed the review. Eleven HCP settings were represented. Three themes were developed that described the structural barriers experienced by HCPs: **The environment works against us** (limited time with patients, lack of privacy); **Trying to tackle the problem on my own** (lack of management support and a health system that fails to provide adequate training, policies and response protocols and resources), **Societal beliefs enable us to blame the victim** (normalisation of IPA, only present in certain types of women, women will lie or are not reliable).

**Conclusion:** This meta-synthesis highlights the need for structural change to address these barriers. These include changing health systems to enable more time and to improve privacy, training, policies and referral protocols. On a broader level IPA in health systems is currently not seen as a priority in terms of global burden of disease, mortality and morbidity and community attitudes need to address blaming the victim.

**Keywords:** Intimate partner abuse, Intimate partner violence, Health practitioners, Qualitative Meta-synthesis, Barriers
Structural Barrier Themes

The environment works against us
limited time with patients, lack of privacy

Trying to tackle the problem on my own
lack of management support and a health system that fails to provide adequate training, policies and response protocols and resources)

Societal beliefs enable us to blame the victim
normalisation of intimate partner abuse, only presents in certain types of women, women will lie or are not reliable
47 studies
1992-2018
16 United States,
6 Australia,
5 UK and 5 Canada
3 Finland,
2 Columbia and 1 each
Jordan, Spain, Norway,
Italy, New Zealand,
Argentina, Vietnam, the
Netherlands, Jamaica and
Sweden.

Health practitioners’ readiness to address
domestic violence and abuse: A qualitative
meta-synthesis

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Abstract
Health practitioners play an important role in identifying and responding to domestic violence and abuse (DVA). Despite a large amount of evidence about barriers and facilitators influencing health practitioners’ care of survivors of DVA, evidence about their readiness to address DVA has not been synthesised. This article reports a meta-synthesis of qualitative studies exploring the research question: What do health practitioners perceive enhances their readiness to address domestic violence and abuse? Multiple data bases were searched in June 2018. Inclusion criteria included: qualitative design; population of health practitioners in clinical settings; and a focus on intimate partner violence. Two reviewers independently screened articles and findings from included papers were synthesised according to the method of thematic synthesis. Forty-seven articles were included in the final sample, spanning 41 individual studies, four systematic reviews and two theses between the years of 1992 and 2018; mostly from high income countries. Five themes were identified as enhancing readiness of health practitioners to address DVA: Having a commitment; Adopting an advocacy approach; Trusting the relationship; Collaborating with a team; and Being supported by the health system. We then propose a health practitioners readiness framework called the CATCH Model (Commitment, Advocacy, Trust, Collaboration, Health system support). Applying this model to health practitioners’ different readiness for change (using Stage of Change framework) allows us to tailor facilitating strategies in the health setting to enable greater readiness to deal with intimate partner abuse.
Health practitioners’ readiness to address domestic abuse

CATCH MODEL  Commitment/ Advocacy/ Trust/ Collaboration/Health system

Health Practitioners’ Readiness to address domestic violence and abuse

- Having a commitment
- Adopting an advocacy approach
- Trusting the relationship
- Collaborating with a team

Low Health System Support

High Health System Support
All levels

REAL MODEL
Recommendations from syntheses

Focus on all levels individual, practitioners, system and society

Individual level- Where is the love and kindness
Practitioners- Motivations
System- Reflective audit and feedback
Society- Victim blaming and othering
We research and collaborate to transform the health sector response to domestic and family violence.
Transforming the Health system:
Voices of survivors and practitioners
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