

Sustaining Primary Care Responses to Intimate Partner Violence

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Ko Mauao te maunga

Ko Tauranga te moana

Kei Tauranga ahau e noho ana

Ko Ngāi Te Rangi raua Ko Ngāti Ranginui nga iwi o oku tamariki me toku hoa tāne

Ko Claire taku ingoa

Kia whakatōmuri te haere ki mua

To walk into the future

Ki muri ko nga whatu ka kitea

our eyes must be fixed on the past

Abstract

Globally, one in three women will experience intimate partner violence in their lifetime. The impact of violence on health and wellbeing is significant, yet, recognition of the relationship between intimate partner violence and ill-health is poor. Implementing and sustaining effective health care responses to intimate partner violence has proven challenging internationally. New Zealand holds a leading role via the Ministry of Health Violence Intervention Programme. Infrastructure supporting health professionals to respond to intimate partner violence and child abuse and neglect has been implemented across hospitals and selected community settings nationally. However, engagement with the primary care sector has been limited. In this study I explore what affects a sustainable response to intimate partner violence within New Zealand primary care settings.

I utilise complexity theory to reconceptualise a sustainable primary care response to intimate partner violence as a complex adaptive system. Concurrently, I analyse the function of health system documents informing intimate partner violence responsiveness and interview primary care professionals on responding to intimate partner violence as a health issue. I apply a complexity-led discourse analysis to each data source to explore how system interactions at policy and practice levels influence intimate partner violence responsiveness. I then thread the data sources together to show how sustainable responses to intimate partner violence are emergent from interactions throughout the health system.

This thesis argues the under-utilisation of the primary care sector in reducing intimate partner violence is a profound system gap. My use of complexity theory as an innovative qualitative research methodology calls attention to key system interactions challenging the emergence of intimate partner violence responsiveness in primary care. Similarly, I show how complexity may be harnessed to promote intimate partner violence responsiveness. This thesis shows why we need to think differently about how we work to reduce intimate partner violence. Primary care professionals are willing to address intimate partner violence, the next step is to assist the sector in being able to.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Claire Gear

Co-Authored Works

This thesis encompasses three published manuscript and one submitted for publication. For each publication, Claire Gear is the first-author in discussion with Professor Jane Koziol-McLain and Dr Elizabeth Eppel.

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Chapter 1 The health system response to intimate partner violence

1.1 Introduction to the study

Internationally, intimate partner violence (IPV) is recognised as a public health problem of epidemic proportions (World Health Organisation, 2013a). The World Health Organisation defines IPV as any behaviour by a current or former intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours (World Health Organisation, 2013b). One in three women worldwide experience IPV during their lifetime, seriously impacting their health and wellbeing (World Health Organisation, 2013a). Many of these women will seek health care for the effects of violence, without necessarily disclosing IPV (World Health Organisation, 2013a). Health professionals, often unknowingly, will treat the sequela of the violence without addressing the cause (Garcia-Moreno et al., 2015).

Responding to IPV within health care settings is known as a complex problem, involving countless diverse and interacting factors that make it hard to establish cause and effect (Young-Wolff, Kotz, & McCaw, 2016). Despite a considerable body of research, integrating effective and sustainable health care responses to IPV has proven challenging internationally. The best evidence-based practice is still unknown and little progress has been made on the frontline (Garcia-Moreno et al., 2015). Utilising complexity theory, I sought to answer the research question ‘what affects a sustainable response to IPV within New Zealand (NZ) primary care settings?’

The purpose of this study was to call attention to the under-utilisation of the NZ primary care sector in the multisectoral work to address IPV. Primary care is tasked with prevention, to address the root causes of ill-health, yet many health professionals do not make the connection between ill-health and IPV. Clinicians often do not recognise the signs and symptoms of violence and lack confidence in asking (Elvidge, 1996; Taft et al., 2011). Two decades ago in NZ, GPs reported being concerned they were working ineffectively by missing cases of IPV, or intervening poorly (Elvidge, 1996). Still today, there is no adequate policy, funding or resources to support primary care professionals in

responding to IPV (Gear, Koziol-McLain, Wilson, & Clark, 2016). I sought to understand the context and implications of this profound system gap.

This study is distinctive in its use of complexity theory as a qualitative research methodology. I chose to use complexity theory to provide a different perspective of the complex problem. Rather than studying system elements in isolation, complexity theory focuses on the relationships between system elements and how they lead to new system behaviours and structures. With little guidance available in the literature to apply complexity theory as a qualitative methodology, this thesis describes my development of a congruent and novel methodological pathway. I expose system interactions at both policy and practice levels promoting, or challenging, the emergence of sustainable primary care responses to IPV and suggest ways system complexity may be harnessed for solutions. Special attention is paid to a complexity-informed concept of sustainability.

This chapter presents the context the research question arose from. The first section discusses the prevalence and health effects of IPV. I then present why violence within indigenous Māori whānau¹ is different to family violence. The third section introduces the current NZ health system response to family violence, specifically focusing on the primary care sector. Finally, I summarise this chapter and provide an overview of the thesis. The reader should note I understand IPV to be a pattern of cumulative harm that can encompass multiple victims (adults and children), past, current and future (Family Violence Death Review Committee, 2014, 2016). While I focus on IPV, I may also use the term family violence to recognise the extended nature of harms. The reader will also notice interchangeable use of the terms ‘primary health care’ and ‘primary care’. I began this study using ‘primary health care’ to reflect both care-seeker and health professional interactions and wider health system interactions. Change was made to align with the more common use of ‘primary care’ in NZ and is used in this thesis to reflect the diversity of NZ general practice settings. Finally, all participants are referred to as health professionals, including management.

¹ Whānau is extended family, or a group of people considered family, belonging to a hapū (subtribe) and iwi (tribe).

1.2 Prevalence and health effects of IPV

Intimate partner violence (IPV) is a key determinant of ill-health, leading to serious physical, psychological and sexual health effects, and too often, death (Family Violence Death Review Committee, 2014; World Health Organisation, 2013b). Internationally recognised as a gendered problem, IPV overwhelmingly impacts women and children, violating their human rights and generating significant social and economic costs (Garcia-Moreno et al., 2015). In NZ, one in three (34.3%) women will experience IPV in their life time (Fanslow, Robinson, Crengle, & Perese, 2010; World Health Organisation, 2013a). Like other colonised indigenous peoples, prevalence for NZ Māori women is higher, with more than one in two (57.6%) experiencing IPV in their lifetime (Fanslow et al., 2010).

The World Health Organisation has mapped three casual pathways connecting adverse health problems with IPV (Table 1). Broadly, the first pathway relates to how IPV leads to injury and death. The second, more 'indirect' pathway, calls attention to the underlying biological and physiological responses to chronic stress caused by exposure to violence. The third pathway relates to psychological control, a defining feature of many abusive relationships. Coercive and controlling behaviours are used to manipulate social interactions or behaviours such as limiting reproductive and sexual health decision-making and access to health care or medications (World Health Organisation, 2013a). Given the impact on health and wellbeing, it is not surprising prevalence of IPV is found to be higher among women seeking health care (Fanslow & Robinson, 2004; Koziol-McLain, Rameka, Giddings, Fyfe, & Gardiner, 2007; World Health Organisation, 2013b).

Table 1: Examples of health effects caused by exposure to violence

Physical Trauma
Visible injuries to face, head, neck, thorax and abdomen, or death
Psychological trauma and stress
Mental health: PTSD, anxiety, depression, eating disorders, suicide, substance abuse, Non-communicable diseases: cardiovascular disease and hypertension Somatoform disorders: irritable bowel syndrome, chronic pain and chronic pelvic pain
Fear and control
Perinatal and maternal adverse health effects: low birth weight, prematurity and pregnancy loss, unwanted pregnancies, abortion, HIV, other sexually transmitted infections (STIs), gynaecological problems

(Black, 2011; Campbell, 2002; World Health Organisation, 2013a).

Health system responses to IPV are underpinned by a public health framework focused on preventing and mitigating the effects of violence. The framework recognises the influence of socio-ecological determinants of violence which intersect across individual (e.g. mental health), interpersonal (e.g. childhood exposure to violence), community (e.g. community disempowerment) and social/structural (e.g. gender inequities) levels. Mapping the connections between determinants gives an understanding of common risk factors and common protective factors as well as opportunities to prevent and intervene in multiple forms of violence (Decker, Wilcox, Holliday, & Webster, 2018).

Although IPV is heralded as a global public health issue, it is poorly acknowledged within many health systems leaving health professionals ill-equipped to respond to those experiencing violence. The release of the World Health Organisation clinical and policy guidelines in 2013 aimed to address this gap in knowledge. The guidelines recommend, at a minimum, health professionals should provide a first-line response involving facilitating disclosure, offering support and referral, providing medical treatment and follow-up care and documenting evidence. Primary care is strongly recommended as a priority setting for training and service delivery (World Health Organisation, 2013b).

In summary, IPV is one of the most common causes of violence against women globally. Despite the serious health effects, health sectors around the world have been slow to respond (World Health Organisation, 2013b). The four steps of a public health approach define the problem, identify the risk and protective factors, develop and evaluate interventions, and finally, implement effective policy and programmes. For IPV, the body of knowledge on prevalence and health effects is well established (step one and two). However, although many interventions have been trialled, evidencing effectiveness has proven difficult (step three). Further, how best to influence the uptake and spread of interventions across different health care settings is unknown (step four). Literature refers to the unknown variables influencing the sustainability of IPV interventions as ‘context’.

1.3 ‘Context is everything’²

A comprehensive health system approach is recommended to sustainably respond to IPV within health care (Garcia-Moreno et al., 2015; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). This approach involves establishing several response components at provider, institutional and community levels. Once these components are in place, effective, sustainable health care provider responses to women experiencing violence are supported to occur (O'Campo et al., 2011). This approach has been shown to increase screening, identification and referral rates as well as responsive clinician behaviour and clinic culture (Ambuel et al., 2013; Hamberger et al., 2014; Hamberger, Rhodes, & Brown, 2015; Ramsay, Rivas, & Feder, 2005). However, evaluations of health system responses to IPV are scarce (Hamberger et al., 2015). Literature identifying limitations of the health system approach point to an overarching failure to account for complexities inherent in responding to IPV as a health issue (Garcia-Moreno et al., 2015; Hamberger et al., 2015; O'Campo et al., 2011).

The standardised nature of a comprehensive health system response to IPV is not easily adaptable to different settings and contexts (Garcia-Moreno et al., 2015; Gear et al., 2012; Ghandour, Campbell, & Lloyd, 2015; Goicolea et al., 2013). Studies have attempted to address this by incorporating customisable intervention components designed to suit individual general practice needs (Ambuel et al., 2013; Bonds, Ellis, Weeks, Palla, & Lichstein, 2006). Yet the intervention is still challenged by other contexts and complexities at play at the time of the response, such as individual circumstances, victim-perpetrator dynamics and the victim-provider relationship, the influences of which are largely ignored by the health system approach (Ghandour et al., 2015).

Literature shows quality of care is strongly dependent on individual characteristics of the health professional, mediated by personal ideology and motivation (Goicolea et al., 2013; Goicolea, Hurtig, San Sebastian, Vives-Cases, & Marchal, 2015; O'Campo et al., 2011; Tower, 2007). Often, IPV intervention efforts are led by individuals who are motivated to make a change in practice (Gear et al., 2016; Goicolea, Hurtig, San Sebastian, Marchal, & Vives-Cases, 2015). The variance introduced by individual characteristics is viewed as problematic to institutionalising and sustaining

² Quoted from Kelly (2011).

responses to IPV in health care systems (Goicolea, Hurtig, San Sebastian, Vives-Cases, et al., 2015). Health system approaches to IPV also often fail to account for how women themselves respond to the violence they experience (Ghandour et al., 2015; Kelly, 2011; Narula, Agarwal, & McCarthy, 2012; Nicolaidis & Touhouliotis, 2006) and tend to ignore the influence of wider systemic and societal variables, such as social norms that tolerate violence against women (Garcia-Moreno et al., 2015; Thurston & Eisener, 2006). An understanding of the complex contexts IPV occurs within and the strategies women are using to survive is essential for an effective intervention (Kelly, 2011).

In summary, current framing of IPV obscures other contextual factors that also influence an IPV response (Thurston & Eisener, 2006). Literature identifies the components needed to implement a comprehensive health system response to IPV but has only recently begun to grapple with how different contexts influence responding to IPV. A common oversight is being responsive to how different ethnicities and cultures experience and respond to violence. In the next section, I explore how violence is different for NZ indigenous Māori.

1.4 Violence within whānau

Violence within whānau is not synonymous with family violence. The distinction between whānau and family is often blurred with policy and legislation obscuring the relational dynamics of whānau (Te Puni Kōkiri, 2010). More than just the nuclear family, the meaning of whānau is about whakapapa (genealogy) ties to whānau, hapū (tribe) and iwi (extended tribe). In Te Ao Māori (the Māori world), a person becomes known through their whakapapa and also acts as an expression of that lineage (Cram, 2017; Walker, 2006, p. 28). Walker (2006) found multiple meanings of whānau, describing it as ‘of the heart’; specific to cultural or tribal contexts and characterised by shared values, beliefs, stories and knowledge (p. 32). Understanding the distinction between whānau and family is important in understanding issues of violence with Māori whānau.

‘Solutions’ to violence within whānau, dominated and shaped by westernised bodies of knowledge, are now widely regarded as ineffective for addressing violence within whānau (Dobbs & Eruera, 2014; Māori Reference Group for the Taskforce for Action on Violence within Families, 2013). Violence within whānau is intergenerational, rooted in ongoing colonisation, socio-economic

deprivation and trauma (Wilson, 2016). Dhunna, Lawton, and Cram (2018) illustrate how violence, and our individual and institutional responses to violence, become learnt behaviours which impact generations to come. Understanding of violence within whānau must engage with these wider contexts, framed within kaupapa Māori methods of whakapapa and tikanga (Te Puni Kōkiri, 2010).

The kaupapa Māori movement was born out of resistance to colonising practices in education and sought to reconstruct the ‘Māori way’ (Cram, 2017, p. 5; Walker, 2006). In health care, kaupapa Māori research promotes a structural analysis of Māori health disparities and determinants, presenting a much wider concept of health and wellbeing (Cram, 2017). For example, issues of violence for Māori may extend beyond health needs to include social and economic issues such as parenting, housing and education (Dobbs & Eruera, 2014; The Māori Reference Group for the Taskforce for Action on Violence within Families, 2013). Most importantly, kaupapa Māori asserts the validity and legitimacy of being Māori and of Māori-led methods towards health and wellbeing (Māori Reference Group for the Taskforce for Action on Violence within Families, 2013).

Using Te Ao Māori strengths, Māori can successfully address violence within whānau (Māori Reference Group for the Taskforce for Action on Violence within Families, 2013). In 2004, the second Māori Taskforce on whānau violence defined violence within whānau as a transgression on tikanga Māori.

... [It is] the compromise of te ao Māori values. Whānau violence can be understood as an absence or a disturbance in tikanga. Tikanga is defined by this Taskforce as the process of practicing Māori values. The Taskforce believes that transgressing whakapapa is a violence act and that Māori have a right to protect (rather than defend) their whakapapa from violence and abuse (Kruger et al., 2004, p. 10).

Solutions to violence should involve a ‘whole whānau’ approach, emphasising the importance of traditional whānau dynamics and social structures based on tikanga and whakapapa (Dobbs & Eruera, 2014; The Māori Reference Group for the Taskforce for Action on Violence within Families, 2013). The Mauri Ora framework is one conceptual model recognised as successful in increasing the capability and capacity of Māori practitioners and providers working with whānau (Dobbs & Eruera, 2014). However, while the body of knowledge on issues of violence for Māori, by Māori, using

kaupapa Māori methods is slowly growing, the knowledge is scarce (Dobbs & Eruera, 2014; The Māori Reference Group for the Taskforce for Action on Violence within Families, 2013).

In summary, addressing violence within whānau is critical to improving the health status of Māori. Currently, the dominance of westernised knowledge marginalises and undermines Māori ways of responding to violence. An effective response to violence within whānau must be led by Māori, based on Te Ao Māori values and have an understanding of the wider influences on health and wellbeing. Having presented an overview of the context responses to IPV take place within, I describe the NZ health system response to family violence.

1.5 Seeking help within the New Zealand health care system

Research consistently shows women experiencing violence are active help-seekers (Family Violence Death Review Committee, 2014; Fanslow & Robinson, 2010). Data from the NZ Violence Against Women study show more than seventy-five percent of respondents had told someone about the violence. Twenty-four percent reported seeking help from GPs and other health professionals, yet only sixteen percent were satisfied with the help they received (Fanslow & Robinson, 2010).

Internationally, primary care professionals are recognised as service providers those living with violence choose to engage with (World Health Organisation, 2013b). They are a consistent point of contact for women, families and whānau and are most likely to encounter the signs of violence (Family Violence Death Review Committee, 2014; World Health Organisation, 2013b). Primary care is uniquely positioned to intervene early and prevent the escalation, severity and health effects of IPV. While intervention models for primary care services to support women experiencing IPV do exist, for effective and sustainable responses to IPV, health professionals need formal guidance and support (Bair-Merritt et al., 2014; Family Violence Death Review Committee, 2014; Feder et al., 2011; Harwell et al., 1998; World Health Organisation, 2013b, 2014).

The NZ health system is largely funded through general taxation. Health policy and leadership are provided by the Ministry of Health (Table 2). District Health Boards plan, manage, provide and purchase health services for their patient population. Primary Health Organisations distribute public funding to general practices and operate as an intermediate point of contact for both

secondary and primary services (Ministry of Health, 2017a). General practices are a distinctive group as they largely operate as private businesses, autonomous from public governance (Quin, 2009). In 2018, there were 20 District Health Boards, 31 Primary Health Organisations and 1,039 general practices (Ministry of Health Primary Care Team, 2018).

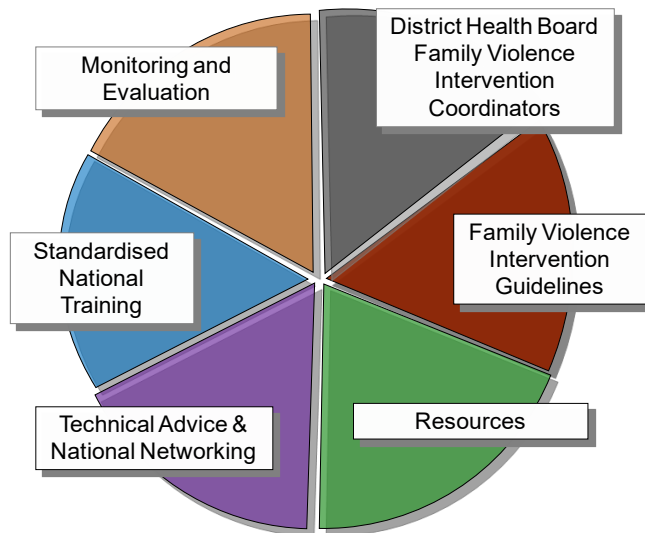
Table 2: New Zealand health system hierarchy

Ministry of Health
District Health Boards
Primary Health Organisations
General Practices

1.5.1 The Violence Intervention Programme

The Ministry of Health Violence Intervention Programme largely represents the NZ health system response to family violence. Launched in 2007, the Violence Intervention Programme seeks ‘to reduce and prevent the health impacts of family violence and abuse through early identification, assessment and referral of victims presenting to designated District Health Board (DHB) services’ (McLean, Koziol-McLain, & Howson, 2018, p. III). The Violence Intervention Programme is premised on a systems approach with six parts, see Figure 1 (Fanslow, 2002; Fanslow, Kelly, & Ministry of Health, 2016; Koziol-McLain & McLean, 2015). The Ministry of Health family violence intervention guidelines underpinning the Violence Intervention Programme recommends a six-step process for responding to IPV: routine enquiry, validation and support, health and risk assessment, safety planning, referral and follow-up and documentation (Fanslow et al., 2016).

Figure 1: Ministry of Health Violence Intervention Programme Systems Support Model (District Health Boards)



From (McLean et al., 2018).

The Violence Intervention Programme has successfully implemented infrastructure supporting health professionals to respond to IPV and child abuse and neglect within hospitals and selected community settings nationally (McLean et al., 2018). Six service locations were targeted for implementation: community mental health, emergency department, child health, alcohol and drug, postnatal maternity and sexual health. Uniquely, the Ministry of Health commissioned a comprehensive longitudinal evaluation of the Violence Intervention Programme, led by the Auckland University of Technology Centre of Interdisciplinary Trauma Research. The most recent evaluation report shows District Health Boards have consistently exceeded the Ministry of Health infrastructure achievement threshold over the last six yearly audits. However, data shows service consistency and quality remain suboptimal. For example, in 2017, only 11 service locations across seven District Health Boards achieved IPV assessment rates of $\geq 80\%$ and disclosure rates of $\geq 5\%$ (McLean et al., 2018).

Violence Intervention Programme engagement with the primary care sector has been limited. Practice resources, adapted from the 2002 Violence Intervention Programme family violence intervention guidelines, are available to inform primary health care professionals in responding to intimate partner violence and child abuse (Gear, Eppel, & Koziol-McLain, 2018b; Ministry of Health, 2000, 2003). In addition, the Ministry of Health, alongside the NZ Police and the Accident Compensation Corporation, contribute funding to the voluntary professional medical body Medical

Sexual Assault Clinicians (MEDSAC). MEDSAC provide medical response to abuse and sexual assault training courses as well as an accreditation programme for volunteer GPs and other primary health care professionals (Gear et al., 2016; MEDSAC, 2017). However, due to a lack of supporting infrastructure such as a dissemination strategy, delivery of training has been limited to interested primary care audiences (Gear et al., 2018b).

In 2012, the Ministry of Health commissioned the Centre for Interdisciplinary Trauma Research (2010) to adapt a United States evaluation tool to guide NZ primary care settings in developing a formal family violence response (Gear et al., 2012; Zink & Fisher, 2007). Similar to the Violence Intervention Programme evaluation audit tools, the Primary Health Care Family Violence Responsiveness Tool was developed using a modified Delphi method. Twenty-nine expert panellists identified 143 ideal primary care family violence response indicators. The final tool was organised into 10 categories to guide phased response development. Subsequently pilot tested within six primary care sites, the tool showed promise for supporting the implementation of a family violence response (Gear et al., 2012).

However, a 24-month follow-up evaluation with three of the original six pilot sites found implementing a response was challenging (Gear et al., 2016). Primary care professionals argued the hospital-based Violence Intervention Programme guidelines required adaptation and resourcing to be appropriate and applicable to primary care. Further, they considered response autonomy important, highly valuing a local response, for the local context supported by local relationships (Gear et al., 2016; Ministry of Health, 2003). Alongside the follow-up evaluation, growing sector interest led to a NZ primary care family violence response network event hosted by the Centre of Interdisciplinary Trauma Research, sponsored by the Ministry of Health. The national event brought together those interested in primary care family violence responsiveness to participate in activities designed to support response development locally, and nationally. The network made recommendations for progress that were submitted to the Ministry of Health, however competing health system priorities meant the recommendations remained unpublished (Gear et al., 2016). The network has not met since.

In summary, the Violence Intervention Programme represents a 'standardised comprehensive systems approach' for responding to family violence, but has yet to effectively engage the primary

care sector (McLean et al., 2018, p. 1). Despite development of resources, uptake of a primary care response to family violence still proved difficult. A different perspective of the problem was needed. It was at this point I became interested in the use of complexity theory for understanding health systems as complex adaptive systems (Gear et al., 2016).

1.6 The perspective of the researcher

I have been involved in family violence research for over 10 years. From 2008-2012 I was fortunate to be employed as a research officer in the AUT University Centre of Interdisciplinary Trauma Research under Professor Jane Koziol-McLain. My main role was as a team member evaluating the Ministry of Health Violence Intervention Programme. It was during this time I was introduced to the work Jo Adams had begun in supporting primary care settings to respond to family violence (Adams, 2005). I then led the development and pilot testing of the *primary health care family violence responsiveness evaluation tool*, formed the national primary care family violence network and hosted the network event. These experiences have interacted with, and in some cases reinforced, who I am and where I stand. I have a strong sense of social justice, human rights and feminism. I also have a strong sense of right and wrong, which often conflicts with my post-structural worldview. My husband and two sons are indigenous Māori, making equity and equality doubly important to me. I volunteer on the collective board of the local women's refuge which keeps me grounded in the realities of family violence.

1.7 Chapter Summary

Intimate partner violence is a global public health problem of epidemic proportions, yet the complexity of the problem, intervention and setting means integration of an effective, sustainable response continues to elude the health care system, particularly within primary care settings. In this chapter I described IPV as a health issue and called attention to numerous contexts that are often obscured by health system approaches to IPV. I described the NZ health system response and the work undertaken to engage the primary care sector to date. This chapter provides the context to begin exploring what affects sustainable responses to IPV in NZ primary care settings. In chapter two, I

consider how complexity theory can provide a different perspective for viewing primary care responses to IPV.

1.8 Overview of thesis

Chapter one presents the context my research question arose from. **Chapter two** is a published manuscript presenting the findings of my literature review across three key bodies of knowledge, intimate partner violence, complexity theory and sustainability. It introduces complexity theory as a methodology for researching complex problems. **Chapter three** is a published manuscript explicating how complexity theory may be applied as a qualitative research methodology. **Chapter four** is a published manuscript presenting the findings of my functional analysis of documents informing intimate partner violence responsiveness in health care. **Chapter five** presents the findings of interview data analysis, describing the Triple R Pathway of each interview participant grouped by general practice. **Chapter 6** describes the Triple R Pathway that emerged from exploring primary care professional discourses on responding to IPV as a health issue, illustrated by four participant exemplars. This manuscript has been submitted for publication. Chapter 6 also presents discussion and implications of both interview data and document data sources together. **Chapter 7** concludes the thesis by synthesising the key contributions my thesis makes to the fields of IPV, complexity theory and sustainability.

Chapter 2 Utilising complexity theory to explore sustainable responses to intimate partner violence in health care

2.1 Prelude

My interest in complexity theory originated from reading a manuscript by Thurston and Eisener (2006). In this manuscript, Thurston and Eisener (2006) point out how health care research seeking to integrate domestic violence interventions ignores the influence of wider structural and systemic elements. They introduce complexity theory concepts for understanding why implementing and sustaining domestic violence protocols is difficult. I was intrigued to consider how wider system structures, such as the impact of gender roles, could influence the implementation of a screening protocol.

This chapter is the product of a lot of reading and learning about complexity theory and how the use of complexity theory would shape my understanding of IPV and sustainability. The following published manuscript presents my findings of a literature review on the three bodies of knowledge key to this study: IPV, complexity theory and sustainability. I show how complexity theory may be used to reconceptualise the complex problem of responding to IPV in primary care settings as a complex adaptive system. The manuscript shows how use of complexity theory can provide insights obscured by other research methodologies.

In the following manuscript I claim the research field knows what components are needed for an effective health care response to IPV and that it is the complexity of the problem that challenges sustainable integration within health systems. I came to this conclusion prior to data collection and analysis, and I now disagree. Instead, I think it is a problem of not being responsive to the complexity. Rather than engaging with the complexity of the problem, we reduce it by trying to identify the key elements of the problem, limit their variation and implement a standard 'best practice'. This insight becomes more evident throughout the thesis.

The literature review presented in the following manuscript sets up a framework to understand IPV responses as complex adaptive systems. This framework helped me to make methodological choices congruent with an application of complexity theory in qualitative research. The following is a

manuscript titled *Complexity Theory in Public Administration – State of Theory and Practice*. The manuscript was published by Taylor & Francis in a special issue of *Public Management Review* on 14 August 2017 and is available online:

<https://www.tandfonline.com/doi/full/10.1080/14719037.2017.1364407>.

2.2 Introduction

Current approaches to public health policy are being challenged to address the increasing complexity of health care service delivery (Ellis, 2013; C. M. Martin & Felix-Bortolotti, 2010). Despite debates on how to apply it, the use of complexity theory for exploring and describing health care organisation and behaviour is increasing (R. R. McDaniel, Jr., Driebe, & Lanham, 2013; D. S. Thompson, Fazio, Kustra, Patrick, & Stanley, 2016). Complexity theory reconceptualises health care systems as dynamic and nonlinear, highlighting characteristics disregarded by other perspectives and providing rich and nuanced accounts of health service delivery and policy (Tenbenschel, 2013; D. S. Thompson et al., 2016).

Intimate partner violence (IPV) is often referred to as a complex problem, alluding to the entanglement of personal, socio-economic and cultural factors that contribute to and sustain violence in people's lives (Family Violence Death Review Committee, 2016; Gulliver & Fanslow, 2016; O'Campo et al., 2011; Spangaro, Zwi, & Poulos, 2009; Taft et al., 2009). The effects of IPV result in adverse health outcomes, leading women who experience IPV to utilise health care services more often than women who have not been exposed to IPV (Bonomi, Anderson, Rivara, & Thompson, 2009; Garcia-Moreno et al., 2015). As one in three women worldwide experience violence by an intimate partner, IPV is a global public health problem of epidemic proportions (World Health Organisation, 2013a).

Internationally, implementing effective sustainable responses to IPV within health care systems and settings has proven challenging and the best evidenced-based model is still unknown (Garcia-Moreno et al., 2015; Hegarty, O'Doherty, Astbury, & Gunn, 2012; O'Campo et al., 2011). Until recently, research exploring responses to IPV have tended to apply theoretical perspectives and methodologies that obscure the complexities arising from interactions within and between the problem and the response settings (Garcia-Moreno et al., 2015; Hamberger et al., 2015; O'Campo et al., 2011). In recognition, research designs are seeking to capture and value different types of knowledge, a wider range of meaningful outcomes for women, and different process information (Decker et al., 2012; Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015; Spangaro, Koziol-

McLain, et al., 2016; Spangaro, Zwi, & Poulos, 2011). Conceptualisations of sustainability in health care are also trending toward an ecological or complex-systems approach, emphasising how different influences interact with complex interventions over time (Fleischer, Semenic, Ritchie, Richer, & Denis, 2015; Mohrman, Shani, & McCracken, 2012; Wiltsey Stirman et al., 2012). The blending of these emerging bodies of knowledge opens new opportunities for improving our understanding of what impacts sustainable responses to IPV in health care, utilising research approaches designed to work with such complexity.

This manuscript presents complexity theory as a methodology for researching the complex problem of responding sustainably to IPV. We begin by providing an overview of complexity theory use in health care and its implications for how we conceptualise sustainability for complex systems. We then describe the New Zealand (NZ) health care response to IPV as an example of a complex adaptive system in action, before proposing a complexity friendly methodology for research into exploring sustainable responses to IPV. In the conclusion, we consider how this approach may be applicable for other complex social systems.

2.3 Complexity theory application in health care

Theory-informed approaches to health care are increasingly demanded to make explicit the assumptions underpinning health system investments (C. M. Martin & Felix-Bortolotti, 2010; D. S. Thompson et al., 2016). Complexity theory calls attention to how different theoretical perspectives and assumptions underpin how we understand and interpret the behaviour of health care organisations and their interaction with complex interventions (Felix-Bortolotti, 2011; Jordon, Lanham, Anderson, & McDaniel, 2010; Kernick, 2006). How IPV responsiveness in health care is conceptualised plays a big role in how we attempt to address the problem and our choices of intervention (Thurston & Eisener, 2006). Studies testing different models of health system approaches to IPV have traditionally used reductionist research methods, such as randomised controlled trials. While these reductionist approaches have offered an understanding of the system components needed to support an effective health care response (O'Campo et al., 2011), there is increasing recognition these methods obscure the complexity of the problem (Ghandour et al., 2015).

A recent scoping review of complexity theory use in health services research found the theory is especially appropriate in allowing researchers to conceptualise a system as dynamical and nonlinear, rather than reducible and predictable (D. S. Thompson et al., 2016). The review found complexity theory is primarily used as an explanatory tool to describe or explore system interactions and relationships and how they may contribute to system change (D. S. Thompson et al., 2016). Rather than presenting a prescribed methodology, complexity theory provides a set of concepts which enable a different way of viewing phenomena. The scoping review identified 18 complexity concepts in use; the most common being relationships, self-organization and diversity, though there is wide variation in conceptual definition (Tenbenschel, 2015; D. S. Thompson et al., 2016). A strength of complexity theory lies in its ability to bring together different combinations of concepts to provide an analytical framework. Moreover, this framework can be applied in combination with other theoretical frameworks (Tenbenschel, 2015). Complexity theory can provide new insight into the complexity of a problem through understanding the patterns of interactions taking place between system elements at different levels and times (R. R. McDaniel, Jr. et al., 2013). Such complexity is often obscured by reductionist methods, which tends to analyse individual system elements, overlooking the reflexive, nonlinear relationship between them, thereby concealing the whole (D. S. Thompson et al., 2016).

2.4 Health care, complex adaptive systems and sustainability

Complexity theory is often used to reconceptualise health care systems as complex adaptive systems (Ellis, 2013; R. R. McDaniel & Driebe, 2001; R. R. McDaniel, Jr. et al., 2013; Mohrman & Kanter, 2012). A complex adaptive system perspective focuses attention on the interactions between agents within a system (Ellis, 2013). In primary health care, an agent may be an individual such as a general practitioner or a patient, a collective such as a group of nurses or general practice, or an entire primary health care organisation. Each of these agents hold information about the part of the system they exist within, but do not hold knowledge of the entire system. As agents interact with one another they generate knowledge that they learn from and respond to, acting and reacting to other agent actions. This process facilitates agent mutual adaptation and co-evolution as agent actions alter the landscape they operate within, as well as their relationships with other agents. The repeated patterns of

interaction between agents as they co-evolve generate self-organization – new forms or behaviours which spontaneously emerge within the system. Over time, repeated self-organization results in the emergence of new system properties, such as responsiveness to IPV, or intervention sustainability (Jordon et al., 2010; R. R. McDaniel, Jr. et al., 2013). Likewise, agent interactions may result in unintended consequences leading to the emergence of system properties that challenge effective and sustainable practices.

Complexity arises from simple causes (interactions between agents) which generate complex effects (health care organisation structure) (Phelan, 2001). The structure of a complex adaptive system cannot be understood through an understanding of individual agent actions in isolation, but as emerging from the continuous nonlinear interaction between agents (R. R. McDaniel, Jr. et al., 2013). Ellis (2013) shows how this perspective provides insight into the ‘subjective and socially constructed nature of primary care’ resulting from the patient community’s interaction with the wider environment (p. p.489). Patients present to general practices with issues that are important to them, stemming from unique socio-cultural, economic and political conditions of their community (Ellis, 2013). Similarly, complexity theory can provide us with insight into what agent interactions influence IPV responsiveness.

The way sustainability is conceptualised has implications for how we design and conduct research, and the possible conclusions which can be made (Gruen et al., 2008; Wiltsey Stirman et al., 2012). Current approaches to IPV responsiveness often conceptualise sustainability as a focal point of interest (e.g. was the original intervention sustained two-years post implementation and initial funding?) (Blasinsky, Goldman, & Unützer, 2006; Bond et al., 2014; Swain, Whitley, McHugo, & Drake, 2010). However, as we become more aware of the different influences which interact with complex interventions and affect sustainability, ecological and complex systems models of sustainability are becoming more useful (Fleischer et al., 2015; Mohrman et al., 2012; Wiltsey Stirman et al., 2012). From a complexity perspective, applying standardised responses or interventions restricts long-term sustainability due to the continuous nonlinear interactions between diverse agents (Booth, Zwar, & Harris, 2013; Felix-Bortolotti, 2009). This unpredictability means sustainability is not an outcome that can be achieved in perpetuity, but a continuous evolving process dependent on

the interactions between multiple factors at different levels of analysis, points in time and settings (Fleischer et al., 2015; Gruen et al., 2008; G. P. Martin, Currie, Finn, & McDonald, 2011; Morden et al., 2015; Scheirer, 2005; Wiltsey Stirman et al., 2012). For example, the implementation and sustainability of a complex intervention is understood as an adaptive process (Wiltsey Stirman et al., 2012). As an intervention adapts to its local setting, it may take different forms (Shani & Mohrman, 2012; Willis, Small, & Brown, 2012). This reflects a period of mutual adaptation between implementation and sustainability, where individual agents in the complex adaptive system find accommodations between maintaining intervention fidelity and promoting sustainability, mediated by stakeholder expectations (Gruen et al., 2008; Hawe, 2015; Hawe, Shiell, & Riley, 2009; Shiell, Hawe, & Gold, 2008; Wiltsey Stirman et al., 2012; Young-Wolff et al., 2016). This theoretical position leads to the conclusion that intervention sustainability is an emergent phenomenon which arises from these interactions between the agents (Bender & Judith, 2015; Mohrman et al., 2012). Complexity theory then becomes fundamentally useful in studying the complex and dynamic nature of sustainability. This approach allows strategic intervention in future interactions to accelerate self-organisation and the emergence of system structures that support effective sustainable responses to IPV (Ellis, 2013; Mohrman et al., 2012; D. S. Thompson et al., 2016).

2.5 The New Zealand health care response to intimate partner violence

The NZ Violence Intervention Programme was established by the Ministry of Health in 2007 to ‘reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to designated District Health Board (DHB) services’ (Koziol-McLain & McLean, 2015, p. 1). The comprehensive, health system approach to family violence (including IPV and child abuse and neglect) is supported by guidelines, funding, standardised training, material and technical resources and ongoing monitoring and evaluation (Fanslow, 2002; Fanslow et al., 2016; Koziol-McLain & McLean, 2015).

In the NZ health system, District Health Boards are responsible for planning, funding and providing health services under the stewardship of the Ministry of Health. District Health Boards provide public funding for the delivery of primary health care services through service agreements

with regional Primary Health Organisations. These agreements require Primary Health Organisations to deliver essential primary health care services to their enrolled patient population, largely through private general practices (Minister of Health, 2016a; Ministry of Health, 2001b; Ministry of Health Primary Care Team, 2018). World Health Organisation (2013b) guidelines strongly recommend health professionals offer first-line support to victims of IPV including facilitating disclosure, offering support and referral, providing medical treatment and follow-up care, and documenting evidence. It is also strongly recommended primary health care is prioritised for training and service delivery. However, in NZ, implementation of the Violence Intervention Programme has largely occurred within hospital-based services. While efforts are increasing to engage primary health care providers (Fanslow et al., 2016), NZ currently does not formally provide adequate policy, funding or resources for a health system response to family violence within primary health care, leaving room for extreme variation, and potentially harmful, responses to victims. (Gear et al., 2016).

Nevertheless, a small network of volunteer primary health care professionals are developing local responses to family violence, supported by limited resources (Gear et al., 2016; Gear et al., 2012; Ministry of Health, 2000, 2003). Tenbenschel (2016) observes three structural tensions of the health care system which may increase the complexity of responding sustainably to IPV within primary health care settings. First, Primary Health Organisations are focused on improving the health of a population, while general practitioners focus on the health of individuals; second, state funded District Health Board contracted outputs are difficult to enforce within primary health care private business models; and third, system hierarchy is undermined by the tacit power of health professionals to adapt health policy through implementation. Gear et al. (2016) reported the experience of a small group of NZ primary health care settings that embarked on developing responses to family violence. The study identified system elements that supported or challenged response development, but found further work was needed to understand how complex health care system relationships could be utilised to effect sustainable responses to IPV in primary health care. The NZ health care response to IPV exemplifies a complex adaptive system in action. The interactions between system agents (such as the World Health Organisation, Ministry of Health, District Health Board, Primary Health Organisation, general practice, Violence Intervention Programme, primary health care volunteer

network and resources) are continuously enabling or constraining the potential actions of other agents in the system. These interactions are generating the structure within which the agents operate – the health care system.

2.6 Reconceptualising primary health care intimate partner violence responsiveness as a complex adaptive system

Complexity theory enables a reconceptualisation of IPV responsiveness as a complex adaptive system, in which interactions within and between the problem (IPV), intervention (IPV response) and the setting (health care) become a primary focus. In this section, we develop a complexity friendly methodology for research into sustainable IPV responses in primary health care settings based on a literature review. The discussion contrasts the features and issues of the current approach to IPV responsiveness with a complexity theory approach with respect to: a) the problem frame, b) the setting, c) research approaches, d) outcome measures and f) sustainability. A summary of the discussion is provided within Table 3. In the conclusion, we discuss how, as an example of particularly complex intervention design and implementation, this conceptualisation may provide transferable knowledge to other complex interventions and policy domains.

Table 3: Reconceptualising primary health care IPV responsiveness as a complex adaptive system

Feature	Current Approach	Issue	Complexity Approach
The problem frame	Health care professionals are well placed to respond to the global public health problem of IPV.	Responses to IPV are often not recognised or implemented. Implementing and sustaining current health-system approaches has proven challenging.	Health care responsiveness to IPV represents a complex problem, requiring a complex intervention, in a complex setting.
The health care setting	Health care organisations are mechanistic and Newtonian in their approach and delivery of care.	Understandings of health care organisations are inconsistent with the complexity of health care. A shift in the models used to frame our thinking is needed.	Health care organisations are complex adaptive systems involving many diverse agents which interact recursively and nonlinearly.
Research approaches to problem	Post-positivist, reductionist methods such as randomised controlled trials which assume a direct relationship between cause & effect.	The complexity of responding to IPV has been obscured by use of reductionist methods typical of traditional research.	Applies complexity concepts to explore or describe patterns of agent interaction which lead to self-organization and

			emergence of new system properties.
Outcome measures	Applies a range of outcomes to reflect IPV intervention effects. No consensus on what measures should be used.	Often conceptualised as an end point of linear cause and effect measured at a fixed point in time, which obscures the myriad of factors between the intervention and a reduction in violence.	Complex intervention rationale or ontology shapes its methods, components and outcomes, affecting the scope and level of knowledge that can be understood and described.
Sustainability	Standardised health-system approach supports effective response but presents challenges for sustainability. Conceptualised as a focal point of interest or state of being.	Current research methods provide little implementation, contextual and process information to support sustainable integration. Increasing awareness of different influences which interact with complex interventions and affect sustainability.	Sustainability is a continuous evolving and adaptive process based on the interactions between multiple diverse agents, at different levels of analysis, points in time and settings.

2.6.1 The problem frame

Despite wide recognition that health care professionals are well placed to respond to those experiencing IPV, the need for a response is often not recognised or implemented (Garcia-Moreno et al., 2015). A comprehensive health system approach, as part of a multi-sectorial response, is advocated to support effective and sustainable health care responses (O'Campo et al., 2011). However, implementing and sustaining these models has proven challenging, resulting in poor integration and wide variation across health systems and settings (Colombini, Mayhew, & Watts, 2008; Garcia-Moreno et al., 2015; Hegarty et al., 2012; O'Campo et al., 2011). Increasingly, scholars are beginning to identify the complexities that arise from the interaction of many different agents involved in responding to IPV in primary health care (Ghandour et al., 2015; Goicolea, Hurtig, San Sebastian, Vives-Cases, et al., 2015), but we have yet to understand how these complexities interact with, and influence, the sustainability of a health system response to IPV (Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015; O'Doherty et al., 2015; Willis et al., 2012). A complexity theory approach emphasises health care responsiveness to IPV as representing a complex problem, requiring a complex intervention, in a complex setting (Family Violence Death Review Committee, 2016; O'Campo et al., 2011; Spangaro et al., 2009). Reframing IPV responsiveness as a complex adaptive

system allows us to explore the complexities that arise from the interaction between system elements which challenge the implementation and sustainability of an effective response to IPV.

2.6.2 Health care settings

Health care system designers, policy makers and guideline authors often conceptualise health care organisations as Newtonian and mechanistic, inconsistent with direct observations and experiences (R. R. McDaniel, Jr. et al., 2013). There is a growing recognition we need a shift in the models used to frame our thinking to understand the complexity of responding to IPV (Family Violence Death Review Committee, 2016; R. R. McDaniel, Jr. et al., 2013; Young-Wolff et al., 2016). Complexity theory allows conceptualisation of health care systems as complex and adaptive involving a large number of elements which interact dynamically and nonlinearly (R. R. McDaniel, Jr. et al., 2013).

2.6.3 Research approaches to the problem

Cognisant of the biomedical model of health and traditional scientific research approaches, randomised controlled trials are consistently recommended to test the effectiveness of IPV interventions, assuming a direct relationship between cause and effect (Ambuel et al., 2013; Bonds et al., 2006; Hegarty et al., 2013; MacMillan et al., 2009; McFarlane, Groff, O'Brien, & Watson, 2006; Ramsay et al., 2005; Taft et al., 2011). Often, women are 'screened' (asked direct questions about different types of violence) to facilitate disclosure of IPV, yet randomised controlled trials and other quantitative studies have encountered difficulties in producing positive and consistent findings on the effectiveness of interventions like screening (Hamberger et al., 2015; MacMillan et al., 2009; Wathen & MacMillan, 2003). A lack of context appreciation in these studies is cited as a reason why little impact is found, highlighting a need for qualitative methods to inform and complement quantitative study findings and offer a wider perspective of whether screening is effective (Decker et al., 2012; Garcia-Moreno et al., 2015; Hamberger et al., 2015; O'Campo et al., 2011). Qualitative studies emphasise influences on IPV responses such as the individual motivation and ideology of the health professional (Goicolea et al., 2013; Goicolea, Hurtig, San Sebastian, Vives-Cases, et al., 2015; O'Campo et al., 2011; Tower, 2007), or response champion (Gear et al., 2016; Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015), how women themselves respond to violence (Ghandour et al., 2015;

Kelly, 2011; Narula et al., 2012; Nicolaidis & Touhouliotis, 2006; Spangaro, Herring, et al., 2016; Spangaro, Koziol-McLain, et al., 2016) and wider systemic and societal influences (Garcia-Moreno et al., 2015; Goicolea et al., 2013; Kelly, 2011; Thurston & Eisener, 2006; Tower, 2007). This suggests the need for a more complex research design to capture the complexity of intervening in IPV in health care settings (Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015).

Complexity theory theorises that in order to understand the complexity of a problem we need to understand the patterns of interactions which are taking place between agents of the system at different levels and times (R. R. McDaniel, Jr. et al., 2013). Moreover, we must consider the heterogeneity of agents and their influence on those interactions. Agents are not all the same. They hold both different micro-diversities (e.g. the mix of health professionals that constitute a general practice) and macro-diversities (e.g. different specialities of general practices) that influence their ability to respond to change in their environment (Boulton, Allen, & Bowman, 2015). Viewing health care as a complex adaptive system shows how both agent heterogeneity and their patterns of interaction lead to self-organization and the emergence of new system properties. The nonlinearity of interactions between diverse agents means there is irreducible uncertainty about how things will unfold. Small changes may lead to big effects and vice versa (Ellis, 2013; R. R. McDaniel, Jr. et al., 2013). The implications of this unpredictability are illustrated in the next section which considers complex interventions.

2.6.4 Complex interventions

A complexity informed view of a primary health care response to IPV understands intervention outcomes as 'co-created' by the different agents in the system (D. R. Thompson & Clark, 2012). No two interventions can be the same, even if strictly controlled, due to the unique interaction between parts at different levels which contribute to the intervention (R. R. McDaniel, Jr. et al., 2013). Each part of the intervention is underpinned by tacit ontological assumptions which influences its interaction with other parts (A. M. Clark, 2013). The degree of complexity generated by interactions between parts at the time of the intervention influences intervention outcomes, and further, how we interpret and value those outcomes (A. M. Clark, 2013; D. R. Thompson & Clark, 2012, p. 278). This

unpredictability raises significant problems for integrating a standardised intervention, as cause and effect will always be uncertain (Ellis & Herbert, 2011; R. R. McDaniel, Jr. et al., 2013). As Goicolea, Hurtig, San Sebastian, Vives-Cases, et al. (2015) found; ‘adequate detection of women suffering from IPV is a complex process that requires more than asking questions and following the steps of a protocol’ (p. p.9). Complexity theory allows us to explore or describe this behaviour by applying selected complexity concepts (Tenbensen, 2015; D. S. Thompson et al., 2016). These concepts can be applied alongside other theoretical frameworks such as critical realism (A. M. Clark, 2013), realist evaluation, action research, or systems dynamic mapping (Best et al., 2016) creating potential to engage in cross-discipline research, overcome knowledge dichotomies and foster interdisciplinary collaboration (C. M. Martin & Felix-Bortolotti, 2014).

2.6.5 Outcome measures

A range of outcome measures are used to reflect the impact of IPV interventions. Outcome measures are widely debated in the literature with no consensus on what is most appropriate (Bair-Merritt et al., 2014; Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015; Nicolaidis & Touhouliotis, 2006; Spangaro et al., 2011; Wathen & MacMillan, 2003). Quantitative studies tend to use outcomes as the endpoint of a linear cause and effect intervention measured at a fixed point in time (such as ‘re-abuse’ or ‘violent events’), obscuring the myriad of factors between screening and a reduction in violence (O'Campo et al., 2011; Thurston & Eisener, 2006). In contrast, qualitative studies tend to acknowledge the problematic nature of outcome measures in accounting for the complexities of responding to IPV and work towards identifying and measuring other valuable outcomes such as reduced isolation, naming abuse (Spangaro et al., 2011), or disclosure and safety planning (Taft et al., 2015).

Current methods testing complex interventions such as randomised controlled trials do not account for the complexity of diverse concepts and multiple outcomes (C. M. Martin & Felix-Bortolotti, 2014). Further, the complexity of the interactions between agents contributing to a complex intervention causes uncertainty for predicting outcomes (Paterson, Baarts, Launsø, & Verhoef, 2009). Complexity theory emphasises how the rationale or ontology of a complex

intervention shapes the methods, components and outcomes, affecting the scope and level of knowledge that can be understood and described (A. M. Clark, Briffa, Thirsk, Neubeck, & Redfern, 2012; Paterson et al., 2009). Recognising this complexity can facilitate a different interpretation of outcomes for complex interventions which address aspects of process (such as new meaning and understanding) and longer term changes in health and wellbeing (Paterson et al., 2009)

2.6.6 Sustainability

As argued earlier, complexity theory conceptualises sustainability not as an outcome state, but as an ongoing dynamic process that arises from the interactions between multiple agents within a system. Research designs often provide limited information on how a comprehensive health system response can be integrated into practice sustainably (Decker et al., 2012; Hooker, Small, Humphreys, Hegarty, & Taft, 2015; O'Doherty, Taket, Valpied, & Hegarty, 2016). Randomised controlled trials provide little implementation information as it occurs (O'Doherty et al., 2016) and research methodologies which account for the impact of contextual factors and sustainability are scarce (Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015). Often, the distinction between implementation and sustainability is blurry (Fleischer et al., 2015; Willis et al., 2012). Using complexity theory, these processes may be better understood as agents that interact with one another in a complex system (e.g. implementation affects sustainability and if the intervention is not sustained, implementation fails) though this interaction needs further research (G. P. Martin, Weaver, Currie, Finn, & McDonald, 2012; Willis et al., 2012).

Increasingly, attention is being paid to process information. This includes the multi-step process of the comprehensive health system response to IPV (O'Campo et al., 2011), the process of disclosing IPV (Goicolea, Hurtig, San Sebastian, Vives-Cases, et al., 2015; Kelly, 2011; McFarlane et al., 2006; Spangaro, Herring, et al., 2016; Spangaro, Koziol-McLain, et al., 2016), clinical system processes such as scheduling of appointments or care continuity (Narula et al., 2012), implementation processes such as provider screening or comfort, or the identification pathway (Decker et al., 2012), research process effects such as unintentional intervention (Hamberger et al., 2014; O'Doherty et al., 2016) and women's progress following IPV screening (Decker et al., 2012; Koziol-McLain, Giddings,

Rameka, & Fyfe, 2008; Spangaro et al., 2011). This process information reflects what is emerging from the interactions between different agents. Traditional conceptualisations of sustainability often obscure this dynamic and emergent nature of knowledge.

Complexity theory is fundamental in understanding sustainability as an evolving and adaptive process generated by the interaction between agents (Bender & Judith, 2015; Mohrman et al., 2012). A sustainable health care response to IPV relies on the interaction between the complex world in which the women lives and the complex health care system. For example, a woman entrapped by IPV seeks health care for the effects of the violence, where she interacts with the complex health system response to IPV. An effective and sustainable health care response to IPV emerges when the interaction between the two complex systems (the women and the health care setting) cause each to mutually adapt in ways which generate positive outcomes for both the woman (e.g. reduced violence) and the health professional (e.g. increased confidence and capability in responding). Utilising complexity theory enables us to conceptualise sustainability as an emergent phenomenon which occurs when a sufficient level of interactive engagement between the complex worlds generates mutual understanding, adaptation and solutions, increasing the likelihood of positive outcomes.

2.7 Conclusions

Use of complexity theory is increasing in health care research, calling our attention to new ways of thinking about complex problems. Responding sustainably to IPV in health care is a persistent problem of particular complexity for public health policy internationally. We know what is needed for an effective health care response to IPV, yet the complexity of the problem continues to challenge sustainable integration in health care systems. There is increasing recognition the research methods that test health system responses are obscuring the complexity of the problem. Scholars are beginning to pay more attention to what contextual factors influence IPV responses and how they work in tandem with health system components.

The utilisation of complexity theory for researching this complex problem contrasts with the current approach by creating greater fidelity between the nature of the system under investigation and the research methodology. As we begin to acknowledge the complexity of health and social systems,

complexity theory facilitates a blending of multiple actor's knowledge enabling new insights into complex emergent phenomena like sustainability. In addition, the focus on emerging outcomes over time that are systemic and evolving provides a more holistic and sustainable basis for assessing interventions. Understanding that there cannot be a single definitive 'solution' to the complex problem naturally arises from this perspective. Instead the system must be continuously directed towards the desired state, through strategic intervention in agent interactions. This requires a significant shift in how we engage with systems that exhibit the features of complex adaptive systems.

The next steps are to apply this theoretical framework to diverse NZ primary health care settings to explore agent interactions that promote or challenge sustainable responses to IPV in primary health care. This innovative use of complexity theory as a research methodology necessitates careful, clear and deliberate selection of research methods to both identify and explore relevant agent interactions as well as understand the scope of knowledge which can be understood and described. It also requires an adaptive study design that allows responsiveness to findings as they emerge. In particular, the conceptualisation of complex system sustainability as an emergent phenomenon will be explored. Finally, the proposed framework lends itself to adaptation for researching other complex social interventions exhibiting multiple interacting elements generating complex problems.

Chapter 3 Advancing complexity theory as a qualitative research methodology

3.1 Prelude

My challenge was to find a methodology congruent with complexity theory and my post-structural positioning. I wanted to expose the limitations of reductionist methodologies and emphasise the complexity of responding to IPV in primary care. I explored use of many different methodologies such as system dynamics modelling, deconstruction, sustainable transitions with a multi-level perspective and discourse analysis and its variants, critical, pragmatic and narrative. Each of these methodologies focused on the relationship between system elements.

The following published manuscript shows how I wove together my methodological approach as complexity-led narrative discourse. It indicates the methods of analysis, which are later explicated in chapter six. Given the uncertainty of how my approach would function, my methodology had to be responsive to what emerged from the data. On reflection, complexity-led narrative discourse analysis focuses on identifying the *functions* within my two data sets: documents and interviews. I had to find out what each document did and what message each participant wanted to convey. For both data sets this involved developing a narrative that helped expose the patterns of interaction occurring in the complex adaptive systems. I found narrative analysis was useful as it did not reduce the complexity, rather it displayed the data in a way that allowed for deeper insight into how the narrative was being generated (De Fina & Georgakopoulou, 2011).

Given the limited guidance on applying complexity theory as a qualitative research methodology, the following manuscript advances both complexity theory application and qualitative research design. The following is a manuscript titled *Advancing Complexity Theory as a Qualitative Research Methodology*. The manuscript was published by Sage Journals in the International Journal of Qualitative Methods on 18 June 2018 and is available online:
<https://journals.sagepub.com/doi/10.1177/1609406918782557>.

3.2 Introduction

Explicit use of theory in research aids understanding of how knowledge is generated, interpreted and manipulated (Cheek, 2000; D. S. Thompson et al., 2016). Deliberate selection and articulation of theoretical perspectives, methodologies, frameworks, models, methods and outcomes is necessary to call attention to the dynamics that influence knowledge (Jordon et al., 2010; C. M. Martin & Felix-Bortolotti, 2010). In health care research assumptions about knowledge often go unacknowledged, triggering calls for improved theory application to support generalizable and robust findings (C. M. Martin & Felix-Bortolotti, 2010; D. S. Thompson et al., 2016). Complexity theory is particularly useful in calling attention to influences on knowledge and is increasingly being used to explain and understand complex health care system behaviour. However, current application of complexity theory within health care research varies widely (Brainard & Hunter, 2016; Braithwaite et al., 2017; R. R. McDaniel, Jr. et al., 2013; D. S. Thompson et al., 2016). In this manuscript we explicate a complexity methodological approach to study the New Zealand (NZ) primary health system response to intimate partner violence (IPV), contributing an innovative perspective on an internationally persistent and complex problem.

Responding to IPV as a health issue is often referred to as a ‘wicked’ or complex problem due to the entanglement of many different factors that sustain violence within families. Moreover, as these factors and possible solutions are continuously co-evolving, there is an absence of a point at which IPV and its effects ‘end’ (Family Violence Death Review Committee, 2014; Young-Wolff et al., 2016). Internationally, IPV is recognized as a public health problem of epidemic proportions due to the significant effects on health and wellbeing and consequent high health service utilisation (Bonomi et al., 2009; Garcia-Moreno et al., 2015; World Health Organisation, 2013b). However, efforts to implement effective health system responses to IPV have proven challenging and little progress has been made on sustaining IPV responses within clinical practice (Garcia-Moreno et al., 2015; Young-Wolff et al., 2016). In NZ, complexity theory is being used to understand the behaviour of the complex systems involved in responding to family violence (Gear, Eppel, & Koziol-McLain, 2017). For example, the Family Violence Death Review Committee (2014) utilised complexity theory to

alter the way we view the problem of family violence and inform a series of shifts to direct the family violence system toward improved service delivery.

We consider complexity theory a useful and critical heuristic to explore the complex problem of IPV. Yet in reviewing the literature, examples of qualitative health care research that consistently applied, or articulated the use of complexity theory across the research design were scarce. We advance this field by exploring the implications of applying complexity theory as a qualitative research methodology. As described by Grant and Giddings (2002), methodology guides a researcher's stance from the formation of the research question to the choice of methods. We share how our use of complexity theory shaped our theoretical perspective, our conceptualisation of the research problem and our selection of methodology and methods. In the discussion, we theorize the implications of complexity theory use for data analysis and reporting and discuss the strengths and limitations of complexity theory as a qualitative research methodology.

3.3 Complexity theory

Complexity theory focuses on understanding the patterns of interaction between system elements at different levels and times, rather than analyzing individual elements in isolation (R. R. McDaniel & Driebe, 2001). Complexity theory provides numerous concepts that can be applied alongside diverse extant theoretical frameworks to view complex phenomena in different ways (Eppel, 2017; Tenbensen, 2015). This facilitates a transdisciplinary approach to research, allowing different bodies of knowledge to be blended to provide a wider understanding of complex problems (Gear et al., 2017; C. M. Martin & Felix-Bortolotti, 2014). For example, Best et al. (2016) combined a complexity lens with system dynamics mapping and realist evaluation to map interactions between system elements that enabled or constrained clinical guideline implementation and how these interactions affected outcomes. They found the use of a complexity lens important for identifying element interactions at different levels, facilitating a deeper understanding of the factors influencing large scale change.

A recent scoping review of complexity theory identified 18 complexity concepts used in health services research (D. S. Thompson et al., 2016). Table 4 provides a description of the most commonly referenced complexity theory concepts, including self-organization, emergence, non-

linearity, feedback loops and path-dependency. Most often, a selection of these concepts have been applied as a framework to guide the research approach or data interpretation (D. S. Thompson et al., 2016). However, there is wide variation in complexity theory application and considerable conceptual stretch or fuzziness remains. Clear articulation of how complexity theory is applied in research design, conduct and outcome evaluation is necessary to support future concept development and use (Brainard & Hunter, 2016; Braithwaite et al., 2017; Tenbensen, 2015; D. S. Thompson et al., 2016). Brainard and Hunter (2016) found some studies of complexity-informed public health interventions cited complexity concepts without “understanding or truly embracing” many aspects of complexity theory, thereby impeding an understanding of the effectiveness of a complexity theory approach (p. 8).

Table 4: Description of common complexity theory concepts

Agent	A system element or part capable of responding to other agent actions and information. Responses may include learning and adaptation. The element may be an individual, collective or process.
Non-linearity	A characteristic of agent interaction generated by unpredictable agent responses to the actions of others.
Feedback loops	Recursive mechanisms arising from multiple agent interactions over time that either reinforce (positive) or undermine (negative) each other. Positive feedback loops support a change trajectory while negative feedback loops tend to undermine or negate change.
Co-evolution	An ongoing process in which agents are influenced by, and mutually adapt to, changes generated by agent interaction.
Self-organization	The spontaneous emergence of new relationships, forms, or patterns of behaviour arising from repeated agent interactions over time.
Emergence	New system properties or levels of complex organization generated by agent self-organization.
Boundaries	An artificial frame, or socially constructed reference point which connects (not separates) a system with its environment. System fluidity means boundaries cannot be defined objectively.
Far-from-equilibrium	A dynamic state in which complex systems maintain a stable appearance by balancing multiple interactions between diverse agents and feedback loops. Stability can be disproportionately disrupted by small changes.
Path-dependency	The influence of system history on current system behaviour and events.
Complex adaptive system	A type of system characterized by endogenous nonlinear dynamism generated by interaction between diverse agents which makes adaptation and spontaneous self-organization possible, but unpredictable.

(Braithwaite et al., 2017; Cilliers, 2001; Eppel, 2017; R. R. McDaniel & Driebe, 2001).

Qualitative research of complex systems has potential to capture and understand complex dynamics that might otherwise be unexplored (A. M. Clark, 2013; Fleischer et al., 2015; R. R. McDaniel, Jr. et al., 2013). The most common method for studying complexity have been case studies (D. S. Thompson et al., 2016). Table 5 shows how scholars have utilised complexity theory alongside case study methodology. The examples also demonstrate the transdisciplinary potential of complexity theory. A qualitative complexity approach has been useful in understanding complex emergent phenomena such as sustainability (Gear et al., 2017; Mohrman et al., 2012) or quality improvement (Ellis & Herbert, 2011; R. R. McDaniel & Driebe, 2001). Although complexity theory may be usefully applied to parts of the research design (as demonstrated in Table 5), we advance this field by considering the implications of utilising complexity theory as a qualitative research methodology to inform the full research design exploring what affects sustainable primary health care responses to IPV.

Table 5: Examples of complexity theory-informed case study research

Anderson, Crabtree, Steele, and McDaniel (2005) demonstrated how complexity theory can be used to extend case study methods and examine system elements not captured using traditional methods.

Booth et al. (2013) applied a qualitative approach to case study collecting interview, document and observation data to explore how chronic illness care changed over a decade in one general practice. Using pattern matching logic they compared understandings of change between traditional implementation science discourse and a complexity informed explanation. They found complexity theory better described how system agents participated in change over time.

Browne, Varcoe, Ford-Gilboe, Wathen, and Team (2015) designed a mixed methods multiple case study to explore the contextual factors which shaped the implementation, uptake and impact of a complexity informed intervention designed to increase equity-oriented care in primary health care clinics. They expect their analysis to show what practice level changes and policy and funding contexts are needed to enhance equity-oriented care.

Felix-Bortolotti (2011) combined complexity theory and political economy to guide analysis of a policy case study on primary health care workforce policy issues and ramifications. She found complexity theory helped to understand the forces which impinge on primary health care and why the sector has evolved in a fragmented way.

3.4 The theoretical perspective

The choice of theoretical perspective shapes both the research design and the scope and level of knowledge which can be understood and described (Patton, 2002). A complexity approach specifically calls attention to the influence of the theoretical perspective as it naturally presents boundaries to alternative ways of knowing (A. M. Clark, 2013; Paterson et al., 2009). For example, health care systems have been traditionally viewed as Newtonian and mechanistic aided by the use of research methods (such as randomized controlled trials (RCTs) that assume direct relationships between cause and effect (R. R. McDaniel, Jr. et al., 2013). However, scholars are recognizing that such methods obscure complexity arising from interactions between different health system elements (Gear et al., 2017). Complexity theory calls attention to these interactions and how they lead to spontaneous organization and the emergence of new relationship structures (R. R. McDaniel & Driebe, 2001; R. R. McDaniel, Jr. et al., 2013; D. S. Thompson et al., 2016).

Consistent with the focus on interaction, we chose to position our approach within the poststructural paradigm. Poststructuralism focuses on how knowledge is constructed through interaction between concept and language (Cheek, 2000; Cilliers, 1998; Morcol, 2001). For example, a view of IPV as a health issue, represents particular views about our health and how health care should be practiced (Cheek, 2000). This view of knowledge construction helps to theorize about dynamic interactions within complex systems. We can explore how interaction between different system elements influences what we accept to be real (Cilliers, 1998).

The poststructural rejection of an objective ontology maintains openness to interaction between both explored and unexplored elements of a complex system and their continuously shifting nature (Cheek, 2000; Cilliers, 1998, 2011). This perspective is especially useful for this study considering the continuously changing inputs, relationships, outcomes and consequences involved in IPV (Brainard & Hunter, 2016; Family Violence Death Review Committee, 2014; Gear et al., 2017). While complexity theory has also been usefully applied using a realist approach (Byrne, G., & Winter, 2013), we rejected the search for a 'reality' for being at odds with a continuously transforming health care system which generates uncertainty, surprise and multiple possibilities (Begun & Kaissi, 2010).

The poststructuralist perspective reminds us that knowledge of the future is always uncertain and multiple outcomes are possible (Begun & Kaissi, 2010; Cheek, 2000; Cilliers, 1998, 2011).

3.5 The research problem

Responding effectively and sustainably to IPV in health care has proven to be a persistent problem of particular complexity internationally (Garcia-Moreno et al., 2015). Complexity theory provides the means to conceptualise the research problem as a complex adaptive system, focusing on the patterns of interactions between various system elements at different levels and times. Importantly, complexity theory helps to call attention to the influence of facets that are not as easily identifiable, such as the underlying ways we understand and approach each part of an intervention (A. M. Clark, 2013; A. M. Clark et al., 2012).

Complex adaptive systems are made up of diverse agents capable of learning, adapting and responding to changes generated through their interactions with other agents. An agent may be an individual, such as a victim or perpetrator of IPV, a collective, such as a health care organization, or a process, such as a particular intervention (R. R. McDaniel & Driebe, 2001). As agents interact, they mutually adapt in response to change generated. For example, the patient seeks help and the health professional provides a particular set of interventions and support. Over time, the repeated patterns of interaction between agents self-organize into new forms or behaviours; the patient may experience reduced violence and the health professional may increase in capability and confidence. Such self-organization may eventually generate the emergence of new system properties or structure, which constitute sustainable health system responses to IPV (Gear et al., 2017; R. R. McDaniel, Jr. et al., 2013).

However, the nonlinear nature of the interactions between agents creates fundamental uncertainty about how things will unfold. Multiple outcomes are possible depending on how the agents interact and respond to change (Begun & Kaissi, 2010; Crabtree, 2010; Lanham et al., 2013). Small changes may lead to big effects when the initial change is reinforced by other agents and equally, big changes may have little or no effect when change is undone by other agents (R. R. McDaniel, Jr. et al., 2013). Further, the heterogeneity of agents influences their ability to respond to change. Not all agents are

the same, they hold both micro-diversities such as personal motivations and ideologies, and macro-diversities such as professional discipline or organization, which will influence the interaction and outcomes (Boulton et al., 2015). This complexity means complex adaptive systems are continuously changing but are resistant to prescribed change (Best et al., 2016; Booth, Zwar, & Harris, 2010). Applying complexity theory principles, we conceptualised a sustainable health care response to IPV to be when a care-seeker and health professional interact in a way that increases the likelihood of mutually positive outcomes (Gear et al., 2017).

Although we may never be able to accurately predict what will emerge from a complex adaptive system, we can continue to try to understand the different system parts and how they interact to learn more (A. M. Clark, 2013). To date, research has generally focused on demonstrating IPV intervention effectiveness using traditional scientific methods that seek to establish cause and effect (such as RCTs) (Ambuel et al., 2013; MacMillan et al., 2009). Yet, these studies have encountered difficulties in producing positive and consistent findings due to a lack of appreciation for context (Hamberger et al., 2015). In contrast, qualitative research has proved useful in identifying and exploring the complexity involved in responding to IPV as a health issue (Gear et al., 2017). For example, an Australian study which conducted in-depth interviews with 20 women six months after disclosing abuse found that the diversity of women's contexts in their trajectory of abuse, service use, statutory agency contact, prior disclosures and screening impact challenged the idea that a single standard intervention would be able to provide help for all women to be safe from abuse (Spangaro et al., 2011).

Qualitative research has also called attention to a wide range of intervention outcomes, illustrating the amount of context and complexity conventional outcome measures exclude. For example, Koziol-McLain et al. (2008) found asking about IPV could contribute to transforming communities, as women who were screened for IPV went back to their families, friends and communities and passed along resource information. Spangaro et al. (2011) found resource information was used by women with their abuser as an indirect or direct way to name their behaviour. In contrast, quantitative outcomes are often measured as an endpoint of a linear cause and

effect and obscure the myriad of factors occurring between an intervention and a possible reduction in violence (O'Campo et al., 2011; Spangaro et al., 2011; Thurston & Eisener, 2006; Tower, 2007).

Research design can also limit information on how health system responses can be integrated into practice sustainably (Decker et al., 2012; Hooker et al., 2015; O'Doherty et al., 2016). RCTs provide little implementation information as it occurs (O'Doherty et al., 2016) and research methodologies that account for the impact of contextual factors are scarce (Goicolea, Hurtig, San Sebastian, Vives-Cases, et al., 2015). Increasingly, qualitative research is paying attention to 'process information', such as the process of disclosing IPV (Goicolea, Hurtig, San Sebastian, Vives-Cases, et al., 2015; Kelly, 2011), clinical system processes such as scheduling of appointments or care continuity (Narula et al., 2012), or research process effects such as unintentional intervention (Hamberger et al., 2014; O'Doherty et al., 2016).

An understanding of the complexity of the research problem is mediated by the choice of theoretical perspective, methodology and methods. As the field recognizes the complexity of implementing a sustainable, effective health system response to IPV, different theoretical frameworks are being utilised to capture different complexities. These include realist evaluation (Goicolea, Hurtig, San Sebastian, Marchal, et al., 2015), normalization process theory (NPT) (Hooker et al., 2015), action research (Joyner & Mash, 2012), grounded theory (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011), feminist theory (Kelly, 2011), implementation science (Decker et al., 2012), theory of planned behaviour (O'Doherty et al., 2016) and complexity theory (Family Violence Death Review Committee, 2014; Gear et al., 2017). Each perspective has potential to emphasize the diverse complexities involved in responding sustainably to IPV within health care. Viewing our research problem as a complex adaptive system enables us to explore the interaction between these many diverse elements that give rise to the complexity of the problem.

3.6 The methodology

Reconceptualising the research problem as a complex adaptive system focuses our attention on the interaction between agents and the communication that takes place between them (Jordan et al., 2009). Consistent with complexity theory, our theoretical perspective (poststructuralism) and research

problem (responding effectively and sustainably to IPV in health care), we chose to adopt a pragmatic approach to discourse analysis, viewing discourse as a complex adaptive system (Beckner et al., 2009; Jordan et al., 2009; Larsen-Freeman & Cameron, 2008). As agents interact within a complex adaptive system, they act and react to the contribution of the other, influenced by their individual diversities. Over time, these dynamic patterns of interaction may self-organise into routinized ways of interacting, leading to the emergence of dominant discourses (Beckner et al., 2009; Jordan et al., 2009; Larsen-Freeman & Cameron, 2008). From this perspective, discourse is not static, but continuously emerges from the dynamic patterns of interaction between multiple agents. The prevailing discourse(s) shapes what we accept as being real at a particular point in time, affords it legitimacy and authority, and influences our approach to future agent interaction (Beckner et al., 2009; Cheek, 2000; Larsen-Freeman & Cameron, 2008).

Discourse simultaneously shapes individual and organisational meaning, values and identity, and blocks alternative ways of learning, communicating and knowing (Cheek, 2000; Larsen-Freeman & Cameron, 2008). For example, the current health response to IPV is dominated by a public health discourse which presents IPV as a modifiable problem with scientifically measurable causes and outcomes (Sweet, 2015; World Health Organisation, 2002). This discourse keeps knowledge of IPV tightly defined within a 'scientific evidence-base' marginalising other bodies of knowledge which may contribute to a wider understanding of the problem. For example, critics of the public health approach argue it medicalizes abuse, presenting women as the population group in need of the intervention, rather than the perpetrators of the violence (Sweet, 2015; Tower, 2007). Others are cognizant of the simplicity of the public health approach, arguing the approach does not account for the complexities of the problem, such as the context of entrapment the victim faces (Kelly, 2011; Nicolaidis & Touhouliotis, 2006). From a complexity perspective, we can argue the public health discourse functions to inadequately represent and respond to the problem of IPV by limiting the bodies of knowledge it interacts with. This discourse may operate to constrain system agents in developing and delivering an effective and sustainable response to IPV.

We sought to explore health system discourses which shape how health professionals respond, or do not respond, to their patients who experience(d) IPV. Viewing discourse as a complex adaptive

system allows us to explore much deeper into discourse, to view how diverse agents, such as funders, policy makers, professional groups, doctors or social workers, identify, define and prioritise IPV as a health issue. We can then explore how these ideas are influenced by their interaction with other agents in the system, and how this contributes to, or blocks, the emergence of discourse(s) that influence sustainable responses to IPV. Our research approach suggests agent interactions at multiple levels will influence the sustainability of an IPV response, meaning there is no one definitive solution to the problem (Gear et al., 2017; Shani & Mohrman, 2012; Wiltsey Stirman et al., 2012). Instead, the complex adaptive system approach allows us to strategically intervene in agent interactions to accelerate the emergence of discourses which underpin sustainable IPV responses (Gear et al., 2017; Mohrman et al., 2012). For example, discourses which value IPV responsiveness could be promoted with specific agents (G. P. Martin et al., 2012), through initiatives such as health promotion posters that advise patients their health professional can help, or health professional education on how responding effectively to IPV can improve the overall health of families.

3.7 The methods

We selected document analysis and participant interviews to access discourses operating at both the health system and practice levels. Concurrent use of these two methods provides potential to explore the interaction between health system levels, exposing gaps between parts of the system that challenge sustainable IPV responsiveness (Braithwaite, 2010; Rapley, 2007). Beginning the process with document analysis can provide an understanding of the context in which interview participants operate and help to inform interview questions (Bowen, 2009; R. R. McDaniel, Jr. et al., 2013). Similarly, participant interviews can call attention to how document discourses were being interpreted, manipulated and adapted in practice by health professionals.

3.7.1 Document analysis

Documents represent an aspect of reality at a particular point in time, providing a static illustration of discourses in play (Cheek, 2000; Rapley, 2007). Rather than analysing the content of documents, we chose to focus on the function(s) of documents, as understanding the content alone, does not show how a document is used and applied by system agents (Prior, 2008). Focusing on a document's

function illustrates what they do rather than what they say, enabling an understanding of how documents are positioned and manipulated by agents across different parts of the system (Prior, 2008). Document function(s) can be elicited by reading secondary material such as media releases, websites or research papers that offer different perspectives of the document under study (Prior, 2008; Rapley, 2007). Secondary material also aids analysis by placing a timeline and context around the selected documents. Examples of questions that may be drawn on to elicit document function(s) include: What is the document's political or ideological purpose? (Shaw, Elston, & Abbott, 2004). How is the document used and integrated into various kinds of knowledge networks? (Prior, 2008). What voices have been heard, or not? (Bowen, 2009). What is the broader discourse the document sits within? (Rapley, 2007).

For example, the NZ primary health care strategy is a high-level policy document which guides and shapes the health care sector (Ministry of Health, 2001b). It was first introduced by the government in 2001 to address health system problems attributed to high-levels of patient co-payments specified by general practitioners (primary health care doctors) (Gauld, 2008; King, 2001; Quin, 2009; Tenbenschel, 2016). The strategy established an intermediate layer of system organization called 'Primary Health Organisations' along with a funding model that provided capitation based on the characteristics of enrolled Primary Health Organisation populations (Ministry of Health, 2001b). In this manner, the strategy functioned to regulate patient co-payments and reduce the medical dominance of general practitioners. Analysis calls attention to a hidden political agenda not evident within the text itself which shaped the purpose of the document (Gauld, 2008; Tenbenschel, 2016). A second layer of analysis may then be applied to consider what discourses the document function produces, contributes to, or hides. Consistent with a complexity approach, these functional discourses should not be viewed as static, but as exhibiting features of a complex adaptive system, illustrating how knowledge is acquired, structured, organized and changed over time (Beckner et al., 2009; Boulton et al., 2015; Larsen-Freeman & Cameron, 2008).

3.7.2 Participant interviews

Interviewing frontline health professionals provides opportunity to explore and capture the complexity of responding to IPV in practice. Recruiting a range of diverse general practices and health professionals provides access to different macro and micro-diversities represented within the complex system of primary health care. As noted, utilising complexity theory as a qualitative research methodology can facilitate deeper exploration of how system agents interact to produce discourse. For these reasons, use of an interview guide with potential lines of inquiry is not feasible. Simply the diversity of participants means standardised questions are impractical. For example, a Primary Health Organisations manager cannot comment on how frontline professionals respond to different situations.

In contrast, an unstructured conversational style allows participants to share what they consider important, facilitating wide-ranging responses reflective of different agent macro- and micro-diversities. It also allows for responses beyond the known research problem boundaries, eliciting further complexity. For example, interactions between IPV and different aspects of family harm, socio-economic issues such as housing and mental health and alcohol and drug issues. The style of complexity-led interviews differs markedly from others such as phenomenological or narrative interviews. Complexity and diversity can be better elicited by holding a vision of the phenomenon being explored during interviews, i.e. our conceptualisation of a sustainable response to IPV, and improvising probes to explore participant knowledge and experiences in-depth, for example, what influenced you to respond the way you did? This style can help to achieve rapport, identify local contextual factors and call attention to agent interactions which are generating self-organization (Lanham et al., 2013).

Preconceived ideas about the phenomenon being studied is a common obstacle for qualitative researchers (Patton, 2002). A qualitative complexity researcher is further challenged as holding certain ideas about an open and constantly changing system is difficult (Jordon et al., 2010). Challenging preconceived ideas about the research problem is critical in working with complex systems that are constantly evolving (Jordon et al., 2010). Researcher reflexivity can be promoted through regular research team conversations which challenge assumptions as they arise, such as why

do primary health professionals assume women's refuges (shelters) are full? Is IPV grounded in the public health approach in practice or only in theory?

Complex adaptive systems continuously change due to agent ability to learn from their interactions with others (Jordon et al., 2010). A complexity-led interview often acts as an agent of change for participants. For example, the interview can prompt participants to review their family violence policy, ask colleagues about how they were responding to violence or discuss the issue within peer groups. Agent learning itself can increase, or reduce diversity (Jordon et al., 2010). A complexity-led interview involves learning by both the researcher and participant as they interact. For example, participant knowledge and understanding of IPV as a health issue may evolve during the interview. Similarly, the researcher's understanding of how health professionals respond to IPV in practice is likely to evolve with each interview.

3.8 Discussion

When we design research, we consider what methodologies and methods would best serve to answer the research question. Sometimes there is a well-worn methodological track and few choices are necessary. Other times, the pathway is less clear. The choice of methodologies and methods reflects our approach to the research problem but we must also critically reflect on how our approach shapes the construction of knowledge and our understanding of the research problem (Cilliers, 1998; Grant & Giddings, 2002; R. R. McDaniel, Jr., Lanham, & Anderson, 2009; Paterson et al., 2009). Just as research design frames what we understand, it also limits alternative ways of understanding. Different selections of theoretical perspectives, methodologies and methods can inform different approaches and understanding (R. R. McDaniel, Jr. et al., 2009).

The use of complexity theory for exploring sustainable responses to IPV in health care represents greater fidelity between methodology and research problem than other more traditional methods (Gear et al., 2017) (Gear et al., 2017). Qualitative research methods have proved useful in exposing the complexity involved in responding to IPV. However, little is known about applying complexity theory as a qualitative methodology in health care research. The complexity philosophy - a myriad of continuously interacting elements in an open system - allows an innovative

methodological turn by blending diverse bodies of knowledge (Gear et al., 2017; R. R. McDaniel, Jr. et al., 2009). This manuscript considered the implications of utilising complexity theory as a qualitative research methodology, while presenting a possible framework for exploring and describing the behaviour of a complex adaptive system.

The next challenge is to explore how complexity theory informs data analysis. Consistent with complexity principles, we expect analysis to be adaptive and responsive to real-time findings as we interact with the data. As our methodology indicates, we seek to understand how discourse emerges from patterns of interaction between agents. Supported by NVivo (v.11) we intend to bring together data sources and broadly code for areas of ‘talk’ about IPV i.e. how is IPV talked about? An example could be how do primary health professionals identify the need to ask about IPV? Conversely, an absence of ‘talk’ about IPV within document data may indicate competing discourses. We intend to conduct a second round of analysis to delve deeper into each of the codes to consider how ‘talk’ produces, contributes to, or hides different discourses. Use of NVivo facilitates data exploration in different ways, such as by participant, general practice, profession, or data source. Central to a complexity analysis, we then intend to demonstrate how these discourses interact to promote or challenge sustainable responses to IPV in primary health care.

A strength of our research design is the concurrent use of document analysis and participant interviews. This is likely to produce rich and diverse data, reflective of diverse global and local efforts on health and violence prevention and intervention efforts across time and a range of participants working in diverse communities, with diverse philosophies, across a range of health and allied disciplines, different levels of expertise and with different understandings of IPV as a health issue. Viewing IPV responsiveness as a complex adaptive system provides a way to explore the patterns of interaction between data sets without obscuring this diversity. Multiple data sources allow testing for pattern consistency and provides opportunity to inquire more deeply into pattern inconsistencies and surprises (Begun & Kaissi, 2010; Patton, 2002; Thurston, Cove, & Meadows, 2008). In particular, the use of both document analysis and participant interviews allows us to explore how the health system and general practice levels interact, enabling insights into gaps between policy and practice when responding to IPV.

Our research design also provides different possibilities for data analysis (e.g. as case studies, across disciplines, across the entire data set, or all methods). Conceptualising discourse as a complex adaptive system emphasizes the continuous construction of knowledge and how it is interpreted, manipulated and adapted by different system agents. This provides multiple ways to view the problem as well as multiple opportunities for influencing the direction of the complex adaptive system. A complexity informed research design allows us to respond to methodological challenges, findings and changes as they emerge (R. R. McDaniel, Jr. et al., 2009).

There are limitations to applying complexity theory as a qualitative research methodology. As noted above, a complexity researchers' foe is preconceived notions and ideas about the system under study. Complexity-led interviewing challenges the researcher to identify and query general assumptions and probe into what influences participant thinking in real-time. The researcher must also learn to apply knowledge acquired from each interview and explore ideas further with the next participant without leading responses. While these are skills that take time to develop, reflecting on, transcribing and learning from interviews may help to curb these challenges. Another obstacle for complexity researchers is the tendency towards reductionism. Research design naturally places boundaries around the complex adaptive system being studied e.g. a limited number of general practices in one region. Analysis can also be reductive, such as coding practices (e.g. content analysis) that 'group' commonalities therefore obscuring micro- and macro-diversities. For example, coding document content (for audience, publisher etc.) will not be an effective way to elucidate document function(s) (Jordon et al., 2010; Patton, 2002). Use of complexity theory requires us be aware of, and articulate, how research design maintains and transforms knowledge boundaries (Cilliers, 2001).

3.9 Conclusions

Responding to IPV in health care has proven to be a persistent complex problem internationally. Scientific methods seeking to establish intervention cause and effect often find it difficult to produce positive consistent findings. Increasingly, scholars are utilising different theoretical frameworks to elicit the complexities of the problem which affect intervention effectiveness and sustainability. This manuscript presented our innovative use of methodology to explore this complex problem.

Although complexity theory is increasingly being used to explore and describe complex health system behaviour, little is known about how we can utilise it as a qualitative research methodology in health care research. This manuscript illustrated how a complexity-led approach shaped our theoretical perspective, our conceptualisation of the research problem, and our selection of methodology and methods. We demonstrated how our research design opened new opportunities for understanding as well as potential limitations. Our use of complexity theory as a qualitative research methodology advances both complexity theory application and qualitative research design. These insights will be useful to researchers exploring other complex systems, interventions and problems. We anticipate the use of complexity theory will contribute an innovative perspective to the considerable body of research that seeks to improve health care responses to IPV.

Chapter 4 Exploring the complex pathway of the primary health care response to intimate partner violence in New Zealand

4.1 Prelude

Ignoring context limits our understanding of the complexity of IPV and our responses to it. As Felix-Bortolotti (2009) said ‘Complexity cannot be adequately understood without the context and location of the subject or the object of study’ (p. 865). I sought to explore the context of the problem by analysing national and international documents informing health care responses to IPV. Not just analysing key documents, this involved a search for secondary documents to know why a document was created and what effect it had. My document analysis was wide, and I developed narratives about the pathways that led to both the current international and national health system responses to IPV.

Documents present a static view of system complexity at a particular point in time. I also held conversations via video-conference with two past policy leaders on the development of the health system response to family violence. This added some qualitative context to the document analysis. My study advisor, Dr Clare Healy, also provided context specifically on general practice involvement in the health system response. Although not included as data, these conversations proved important to challenge some of my preconceptions and learn more about the documents.

As noted in chapter three, I was challenged by a lack of guidance in the literature on applying complexity theory as a qualitative research methodology. This gap offered the opportunity to develop a methodological approach and scope to then build upon it. On reflection, conducting the document analysis provided a ‘first-go’ at applying complexity theory as a methodology. What I learnt from that process informed and improved my analysis of interview data.

Documents capture a state of affairs at a particular point in time, representing policy actors’ specific understanding of an issue. This enables direct access to discourses that policy actors engage with to inform the document. It also provides insight as to how particular policy actors engaged in the solution finding influenced the document, and how the absence of key policy actors or communities impact solution effectiveness. Identifying document function, rather than content, calls attention to the

discourses the document uses to fulfil its function and how different policy actors change or manipulate these for their own purposes. For example, the various forms of family violence intervention guidelines all functioned to promote a public health discourse which focuses on addressing the health effects of violence. Solely reading the content of each guideline does not demonstrate how this dominant discourse has functioned to obscure other ways of understanding and responding to family violence. By declining to endorse, the Royal New Zealand College of General Practitioners used the guidelines to argue for a different approach in primary care. The following published manuscript could have better articulated the distinction between, and analytical potential of identifying document function rather than content.

I conceptualised discourse as a complex adaptive system itself, emergent from patterns of interaction between multiple agents. Far from being static these discourses show how knowledge is acquired, structured, organised and changed over time. However, documents solidify the dominant discourse, shaping what is accepted as real in a point in time, as well as interactions between agents in the future. My analysis process collated the function of relevant documents within a chronological narrative, providing a reference dataset for my complexity analysis. I then coded the chronological narrative using a complex adaptive system lens, focusing on how discourses functioned to enable or constrain agent co-evolution, self-organisation and the emergence of new system structures that challenge or promote sustainable responses to IPV. The implementation pathway narrative described in the below manuscript was generated by that analysis. The chronological analysis was conducted at a particular point in time to support interviewing. Document selection was informed by the writing of the narrative (i.e. documents were sourced in response to gaps in the narrative) and tightly focused on the research purpose. The reader should refer to Appendix D List of documents analysed, for the complete raw data set; documents are available in the public domain. Although omitted within the below manuscript, international documents informed the findings, for example, the public health approach to violence prevention originated from the World Health Organisation Ottawa Charter

The following published manuscript focuses on the NZ health system response to family violence pathway. It provides the context behind current primary care professional responses to family violence. Coupled with health professional interviews, these findings show the relationship

between health systems and health practice. The following is a manuscript titled *Exploring the Complex Pathway of the Primary Health Care Response to Intimate Partner Violence in New Zealand*. The manuscript was published by BMC Springer Nature in the journal *Health Research Policy and Systems* on 24 September 2018 and is available online:

<https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-018-0373-2>.

4.2 Background

Primary health care provides opportunity to disrupt the causes of ill-health, including issues that traditionally fall outside of the health sector, such as intimate partner violence (IPV)^a (World Health Organisation, 2008). Internationally, the health response to violence is now situated within a public health framework focused on preventing and mitigating the health consequences of violence (World Health Assembly, 1996). Primary health care is recognised as a setting uniquely positioned to respond to those experiencing violence, being an entry point into the health system and a first, or only point of contact with professionals who can facilitate access to specialist care and support (World Health Organisation, 2013b). International guidelines strongly recommend primary health care be prioritised for IPV workforce training and service delivery. Health care professionals should, at a minimum, be able to provide a first-line response to those experiencing IPV, including facilitating disclosure, offering support, and referral, providing medical treatment and follow-up care, and documenting evidence. (World Health Organisation, 2013b). However, integrating sustainable and effective responses to IPV in practice has proven challenging across health systems and settings, often being referred to as a ‘complex’, or ‘wicked’ problem (Garcia-Moreno et al., 2015; Gear et al., 2016; Young-Wolff et al., 2016). New Zealand (NZ) has an international lead role on family violence responsiveness in health care, via its Violence Intervention Programme (Fanslow et al., 2016). Infrastructure supporting effective responses to IPV and child abuse and neglect has successfully been implemented within hospital and selected community settings (Koziol-McLain & Gear, 2012). Yet, similar engagement within primary health care has been limited (Gear et al., 2016). Utilising complexity theory, we explored what affects a sustainable response to IPV in NZ primary health care settings.

General practice in NZ is largely autonomous from public governance (Quin, 2009). Under NZ policy settings, general practices receive public funding from the Ministry of Health distributed via District Health Board to their regional Primary Health Organisation under service agreements. In 2016, there were 20 District Health Boards, 32 Primary Health Organisations and 1013 general practices (Ministry of Health Primary Care Team, 2018). Aside from funding primary health care services, District Health Boards are also responsible for the provision of hospital care and some public health and community services (Ministry of Health, 2017a). The Ministry of Health funds the Violence Intervention Programme through individual contracts with each District Health Board (McLean, Koziol-McLain, & Garrett, 2015). For more detail on the NZ health system see (Ministry of Health, 2017a).

Complexity theory facilitates an innovative perspective of complex problems by focusing on the interaction between system elements, rather than studying them in isolation (R. R. McDaniel, Jr. et al., 2013). Instead of providing a prescribed methodology, complexity theory offers numerous concepts which can be combined in different ways, and alongside different theoretical models, to view complex problems in different ways (Tenbenschel, 2015; D. S. Thompson et al., 2016). With increasing application in health care, complexity theory is often used to reframe health care systems as complex adaptive systems (Khan et al., 2018; D. S. Thompson et al., 2016). Complex adaptive systems are made up of many diverse system agents (i.e. individuals or collectives involved in the system) constantly in interaction with, and adapting to, one another. Repeated patterns of agent interaction lead to spontaneous new behaviours (self-organisation) and the emergence of new system structures (R. R. McDaniel & Driebe, 2001).

The complexity of intimate partner violence emerges from the entanglement of many diverse factors which contribute to, and sustain, violence in people's lives. Similarly, the complexity of health care systems emerges from the interaction between the many diverse agents involved in health care. When these two complex systems interact, the number and diversity of interactions between agents makes it difficult to predict how things will unfold. Despite good intentions, agent interactions may generate unintended effects which challenge effective and sustainable practices (R. R. McDaniel & Driebe, 2001). Utilising complexity theory as a research methodology allows us to explore the

interactions between the continuously changing inputs, relationships, outcomes and consequences involved in responding to IPV in health care settings (Gear, Eppel, & Koziol-McLain, 2018a). The concept of a sustainable health care response to IPV evolves into a constantly emerging phenomenon generated by patterns of interaction between agents. This approach is fundamentally useful in calling attention to influences, known or unknown, which affect sustainable responses to IPV over time (Gear et al., 2017).

In this manuscript we demonstrate the potential for a complexity-led approach to open new ways of thinking about, and responding to, complex problems. We trace the implementation pathway of the NZ health care system response to IPV across two decades, focused on the participation of the primary health care sector (see Table 6). We demonstrate how discourse influencing IPV responsiveness emerges from agent interactions, contributing to system gaps and unintended consequences. We call attention to agent interactions that challenge the implementation and sustainability of a health system response to IPV across secondary and primary health care. Our findings are presented within a chronological narrative of implementation.

4.3 Methods

Utilising complexity theory, we viewed a sustainable response to IPV as a complex adaptive system to focus on the interaction between agents and how they communicate within the system (Gear et al., 2018a). We viewed discourse as a complex adaptive system, where dynamic patterns of agent interaction self-organise into routinized ways of interacting, generating discourse phenomena (Beckner et al., 2009; Larsen-Freeman & Cameron, 2008). Put more simply, meaning is generated by the interaction between agents. From this perspective, discourses are not static but continuously emerge from agent interactions; what may be understood in one context may mean something different in another. These discourses simultaneously shape individual and organisational values and identity and block other ways of knowing (Beckner et al., 2009; Larsen-Freeman & Cameron, 2008). For example, a practitioner who describes IPV as a problem only for low socio-economic groups blocks knowledge of IPV dynamics for middle and high socio-economic groups.

A complexity-led discourse analysis allows deeper insights into how diverse agents interact to identify, define and prioritise IPV, both collectively and individually, producing a much more nuanced understanding of the discourses at play. It also calls attention to multiple opportunities to effect system change by strategically influencing agent interactions (Larsen-Freeman & Cameron, 2008). In this study, we chose to analyse documents as they provide a static representation of discourse, representing a specific understanding of an issue at a point in time (Gear et al., 2018a; Rapley, 2007). To access discourses, we analysed the function of key policy, strategy, guideline and evaluation documents. Focusing on the function of the documents, rather than the specific content, provides an understanding of how various system agents position and manipulate health policies shaping a system's primary health care response to IPV (Larsen-Freeman & Cameron, 2008; Potter & Hepburn, 2014). In this manuscript, rather than naming and describing discourses, we map out how discourses have self-organised into a stabilised pattern that constrains primary health care participation in the health system response to family violence. We demonstrate how numerous competing discourses have contributed to system gaps and unintended consequences over time. Further detail on our methodological approach can be found elsewhere (Gear et al., 2018a).

4.3.1 Data collection.

Beginning with easily identifiable documents (e.g. the NZ Health Strategy), we applied a snowball method to source documents connected to contexts in which the document was produced. One document could lead to a variety of other documents and discourses offering an infinite view of system connectedness. We collected data to achieve saturation within the boundaries of this study. Most documents were sourced online through libraries and the Google search engine, hardcopy documents were sourced from the New Zealand Family Violence Clearinghouse Library and the National Library of New Zealand. We sourced 110 documents across three main fields: (1) NZ health care strategies, (2) international recommendations for addressing IPV in health care and (3) NZ family violence prevention and/or intervention documents. Selection was emergent and pragmatic, guided by the question 'What is the relevance of the document to the research problem and purpose?' (Bowen, 2009) Documents were designated as either primary, or secondary material. Primary material (n=33)

included the most recently published version of a document directly influencing IPV responsiveness in NZ primary health care. Secondary material (n=77), not necessarily directly relevant to IPV responsiveness, provided document context (such as document purpose(s) or further information on key issues within the primary documents (such as health target critique). Secondary material included commentary, research reports, websites, media releases, discussion documents, personal communication, or previous versions of the selected primary document. See Appendix D List of documents analysed.

4.3.2 Analysis.

Within each group of documents, each document was analysed to identify function(s), supported by a collation of analysis questions (informed by Bowen (2009); Prior (2008); Rapley (2007); Shaw et al. (2004)) such as ‘how does the document transform our actions and interactions?’ or ‘how is the material called upon or manipulated?’ alongside supplementary knowledge from secondary materials. Working chronologically, these documents were threaded together by their function(s) within an implementation narrative. Applying the complex adaptive system analytical lens, this process called attention to how agent interactions have self-organised to shape implementation direction, contributing to system gaps, and unintended consequences. These insights were written into the narrative as it emerged, generating an implementation narrative which emphasises the complexity of implementing sustainable responses to IPV within NZ primary health care. For the purposes of this manuscript, we focus our findings on the NZ health care response to IPV, creating an artificial boundary that excludes possible interactions between international recommendations and the NZ response.

4.4 Findings

The narrative is structured to call attention to the construction and use of discourses over time, interspersed with ‘events’; defined as a significant occurrence which alters the system trajectory (Hawe et al., 2009; Rapport et al., 2017).

4.4.1 Constructing discourse: The ‘Gardyne’ protocol

The first NZ protocol supporting general practitioners (GPs; primary health care doctors) to respond to IPV was developed in 1995 by an Auckland-based research team who sought to promote IPV as a significant public health policy issue (Elvidge, 1996). The research project focused on GPs as a provider likely to first encounter signs of violence, able to provide early intervention and therefore prevent the escalation, severity and health effects of IPV (Elvidge, 1996). The team developed the ‘Gardyne’ protocol which alongside specialist training, provided GPs ‘practical tools’ for communication, recognition, disclosure, safety and referral across two interventions: women (as victims) and men (as perpetrators) (Gardyne, 1995, p. 5). The protocol was tested with 25 Auckland-based GPs but no evaluation of effectiveness was published (Elvidge, 1996). The team found that, unlike other issues (such as alcohol abuse), there were no resources for responding to IPV and many GPs were concerned they were working ineffectively by missing cases of IPV or intervening poorly (Elvidge, 1996). Interim recommendations included disseminating and implementing the protocol within health services and over time establishing a dedicated health care service for victims of IPV (Elvidge, 1996). This research project may represent the initial construction of discourse phenomena around GP responsiveness to IPV in NZ. The intent to integrate the protocol within health services may be understood as a first attempt to influence primary health responsiveness to IPV from the ‘bottom up’ (i.e. GP developed). However, the impact of this research remains unclear, suggesting interaction with other health system agents were blocked.

4.4.2 Formalising discourse: Establishing policy and guidelines

In 1996, NZ released a Government Statement of Policy on Family Violence, actioning the 1994 New Zealand Crime Prevention Strategy priority to reduce the incidence of family violence (Goff, 2001). The Statement functioned to set a common policy approach for all government agencies involved in responding to family violence (Ministry of Health, 1997; New Zealand Government, 1996). As intended, the Statement principles formed the core of the health system response to family violence, adapted by the Ministry of Health for the first government-led health care family violence guidelines published in 1998 (Ministry of Health, 1997, 1998).

Prior to the 1998 guidelines, health care responses had been ad hoc and largely focused on child abuse and neglect (Ministry of Health, 1998). The 1998 guidelines represented a development phase of the health system response to family violence; functioning as a first policy step toward coordinated and consistent responses (Ministry of Health, 1998). Developed by the Ministry of Health Public Health Group, the guidelines define the health sector role as responding to the adverse health effects of violence through prevention and crisis intervention. The role is framed by the World Health Organisation Ottawa Charter; improving public health by raising awareness of violence, fostering non-violent behaviour as well as access to medical help and a safe environment (Ministry of Health, 1997, 1998; World Health Organisation, 1986). The 1998 guidelines were designed to support health care providers to develop family violence protocols in their local setting, facilitating consistency across the sector while assigning responsibility for development and use of protocols to providers. The Ministry of Health was responsible for disseminating the guidelines and encouraging their use through provider training and contract quality requirements (Ministry of Health, 1997, 1998). Primary health care was identified as one priority setting for initial protocol development and training, referencing the initial 'Gardyne' protocol developed in 1995 (Gardyne, 1995; Ministry of Health, 1998). Defining family violence responsiveness within policy and guidelines set the knowledge boundaries of how health care may respond to IPV (i.e. addressing a public health problem in a consistent manner), establishing a pathway from which future agent interactions would be influenced. However, the strategically planned 'top down' method of implementation was to be challenged by two significant events, the introduction of the primary health care strategy and the death of Riri-o-te-Rangi (James) Whakaruru.

Table 6: Timeline*

1995	First protocol supporting general practitioner responsiveness developed and tested
1996	Government statement of policy on family violence released
1998	Ministry of Health releases first family violence guidelines (October)
1999	Death of Riri-o-te-Rangi James Whakaruru (April) 5th Labour Government elected (centre-left) (September)
2000	Investigation findings into the death of Riri-o-te-Rangi James Whakaruru released (June) NZ Health Strategy released with an objective on interpersonal violence (December)
2000	Ministry of Health Family Violence Intervention Project commences (November)
2001	Ministry of Health releases first Primary Health Care Strategy (February) Ministry of Health introduces the Family Violence Intervention Project (October) District Health Boards established (December)
2002	Pilot testing of the Family Violence Intervention Project begins within four hospital settings (April) Ministry of Social Development launches first Family Violence Prevention Strategy (February) Ministry of Health publishes Family Violence Intervention Guidelines (September) Royal New Zealand College of General Practitioners declines to endorse the Family Violence Intervention Guidelines
2003	Royal New Zealand College of General Practitioners publishes 'Recognising and responding to intimate partner violence' resource (June)
2004	Centre for Interdisciplinary Trauma Research publishes baseline Family Violence Intervention Project evaluation report (November)
2005	Cross-government Taskforce for Action on Violence within Families established (June) Centre for interdisciplinary Trauma Research identifies gap for a primary health care response to family violence
2007	Family Violence Intervention Project concludes pilot testing Ministry of Health Violence Intervention Programme launched
2008	5th National Government elected (centre-right) (November) Ministry of Health funds development and pilot testing of primary health care evaluation tool (November)
2010	Ministry of Health provides Violence Intervention Programme funding to improve responsiveness to Māori Centre for Interdisciplinary Trauma Research makes the primary health care evaluation tool freely available (July)
2012	Centre for Interdisciplinary Trauma Research publishes primary health care evaluation tool development methods and findings, conducts a follow-up evaluation of pilot sites and hosts a national primary health care responsiveness network meeting (May)
2013	The Taskforce for Action on Violence within Families Māori Reference Group publishes E Tu Whānau (May)
2014	Family Violence Death Review Committee publishes the Fourth Annual Report (June) Ministerial Group established alongside cross-government package to reduce family violence (July)
2016	Family Violence Death Review Committee publishes the Fifth Annual Report (February) The Royal College of New Zealand General Practitioners declines to endorse refreshed Ministry of Health guidelines (March) Ministry of Health publishes a revised health care strategy (April) Ministry of Health publishes refreshed family violence assessment and intervention guidelines (June) The Royal College of General Practitioners publish revised quality standards for general practice (September) Centre of Interdisciplinary Trauma Research publishes primary health care follow-up evaluation findings
2017	The Ministerial Group publishes two frameworks for a common and consistent approach to family violence across agencies (June)

*(Events in bold; month included where known)

4.4.3 Event: *The Primary Health Care Strategy 2001*

In 1999, a newly elected government initiated significant health system reform through the NZ Health Strategy 2000 and Primary Health Care Strategy 2001 (Ministry of Health, 2001b; Ministry of Health Manatū Hauora, 2000). This was the first time the government had set a vision for how primary health care would be organised and delivered (King, 2001). Key to the new strategy was a population health approach that organised service delivery around the needs of defined populations, rather than responding to only those who actively sought care. Capitation funding was based on the characteristics of enrolled populations, allowing greater flexibility in service utilisation and reduced costs for patients (King, 2001; Ministry of Health, 2001b).

The strategy established a new layer of organisation, Primary Health Care Organisations and Māori^b Development Organisations, designed to provide a central point of contact for both community and secondary care providers. This intermediate organisational layer was tasked with improving the health of their population by responding to the Health Strategy objectives (Gauld, 2008; Tenbenschel, 2016). Only GPs that joined Primary Health Organisations or Māori Development Organisations were eligible for the new population-based funding. This strategy functioned to make all primary health care professionals responsible for meeting the needs of their populations, reducing the medical dominance of one professional group (such as GPs) (Gauld, 2008; Ministry of Health, 2001b).

4.4.4 Event: *The death of Riri-o-te-Rangi (James) Whakaruru*

During the 2000's health system reform, development of the health system response to family violence was accelerated by the death of four-year-old James Whakaruru on 4 April 1999 from one or more physical assaults by his mother's partner (New Zealand Government, 2000). His death sparked an investigation that found poor communication between statutory agencies had failed to protect James (Office of the Commissioner for Children, 2000). The health sector had had extensive contact with James but failed to communicate the necessary information between practitioners:

James was seen forty times by health practitioners, four presentations at the hospital emergency department, two admissions and one outpatient clinic, three face-to-face Plunket [well child health provider] contacts, and thirty visits to general practitioners at four practices. Collectively the health sector had available a telling picture of James' circumstances. This picture was never put together because of poor communication between practitioners (Office of the Commissioner for Children, 2000, p. 4).

The investigation report made 59 recommendations to be implemented by government agencies (Maharey, 2000, 2001). The Ministry of Health issued a report detailing the health sector response to the findings (New Zealand Government, 2000). Among others, actions included establishing a priority objective within the NZ Health Strategy 2000 to “reduce the incidence and impact of violence in interpersonal relationships, families, schools and communities” (p.vii) (Ministry of Health Manatū Hauora, 2000). This objective was important as it directed the health sector to focus on actions to increase family violence responsiveness. It also set an expectation that newly formed District Health Boards (established in 2001) would implement family violence programmes based on the guidelines (Koziol-McLain et al., 2006).

James' death and the investigation recommendations directed the focus of action toward responding to child abuse and neglect in hospital settings, unintentionally suspending action in primary health care. The 1998 guidelines were to be implemented, hospital-based policies on child abuse management reviewed, a national policy on the use of skeletal surveys for non-accidental injury implemented and national child abuse and neglect guidelines and training developed. Notably, the report observed the difficulty of GPs in gaining oversight of James' social circumstances. This appeared unaddressed by the Ministry (New Zealand Government, 2000).

The events stemming from James's death forced health system agents to co-evolve. The Health Strategy objective shifted responsibility of implementing a response from individual health care providers to the level of District Health Boards. The recommendations held the Ministry of Health responsible for developing national child abuse and neglect guidelines. At the same time, the introduction of the Health Strategy and Primary Health Care Strategy made health providers responsible for reducing the incidence and impact of interpersonal violence within their populations while initiating significant organisational reform across the sector,

particularly within primary health care (Ministry of Health, 2001b; Ministry of Health Manatū Hauora, 2000). It can be argued that the simultaneous introduction of the Health Strategy objective and organisational reform had a negative influence on the uptake of family violence responsiveness in primary health care, an unintended consequence.

4.4.5 Introducing discourse: The Violence Intervention Project

To support District Health Boards in actioning the Health Strategy objective, the Ministry of Health published a Toolkit in 2001 suggesting how the health sector could respond to “interpersonal violence” (p.4) (Ministry of Health, 2001a). Similar to the 1998 guidelines, the Toolkit was framed by public health noting that interpersonal violence is common, associated with significant health effects, high health care utilisation and cost (Koziol-McLain et al., 2006; Ministry of Health, 2001a). The Toolkit encouraged District Health Boards to reduce interpersonal violence through the use of population-based strategies (i.e. health promotion activities) and family violence interventions to identify, assess and refer those experiencing violence (Koziol-McLain et al., 2006; Ministry of Health, 2001a). Again, primary health care was identified as one of ten target services where disproportionate numbers of people experiencing family violence may present (Ministry of Health, 2001a). The Toolkit also promoted creating institutional change by adopting a systems-approach to strengthen health care responses to family violence (Ministry of Health, 2001a). As such, it introduced the Ministry of Health Family Violence Intervention Project as the focus of the health sector response to interpersonal violence.

With the introduction of the Violence Intervention Project, the health system response moved into an implementation phase. The Project aimed to develop the 1998 guidelines alongside three major objectives of (1) establishing practice procedures (or protocols) to identify, assess and refer victims of family violence, (2) funding health professional training and (3) piloting District Health Board implementation of the 1998 guidelines. This work was supported intersectorally by the launch of the first NZ Family Violence Prevention Strategy ‘Te Rito’ by the Ministry of Social Development in 2002 (Maharey, 2002; Ministry of Social Development, 2002) and later, a cross-government Taskforce for Action on Violence within

Families established in 2005 (Ministry of Social Development). This progress was reinforced by the publication of family violence intervention guidelines.

4.4.6 Event: New guidelines

In 2002, the Family Violence Intervention Guidelines: Child and Partner Abuse (2002 guidelines) were published, fulfilling the first objective of the Violence Intervention Project and the recommendations for national child abuse and neglect guidelines and training (Fanslow, 2002; New Zealand Government, 2000). The 2002 guidelines are described as a practical tool for assisting health professionals to identify and respond to family violence through a six-step model in conjunction with 'train-the-trainer' workshops, facilitated by the Violence Intervention Project, fulfilling the second objective of the Violence Intervention Project (Fanslow, 2002; Koziol-McLain et al., 2006). Written generically, the 2002 guidelines were designed to be applicable to diverse health care professions and settings with an expectation of profession-specific adaptations in due course (Fanslow, 2002).

The 2002 guidelines functioned as a fundamental part of the health system response to family violence. Along with the Health Strategy objective, it was expected all District Health Boards would work towards implementing the guidelines (Gulliver, Fanslow, Fleming, Lucassen, & Dixon, 2018; Koziol-McLain et al., 2006). Internationally, health care responses historically focused on addressing child abuse and neglect. Uniquely, the 2002 guidelines extended the focus of the recommendations by recognising the high co-occurrence between IPV, and child abuse and neglect, seeking to guide an integrated response (Gulliver et al., 2018). 'Refreshed' guidelines were published in 2016, aligning with updated policy, research and practice information (Fanslow et al., 2016; Ministry of Health, 2017b). Rather than being adaptable to different settings, the refreshed guidelines strongly advocated for a 'whole of system' approach family violence intervention and assessment. They note the growing efforts to address family violence in primary health care and place "increased emphasis" on planning care transitions, such as between secondary and primary health care (p.1) (Fanslow et al., 2016, p. 1). Nevertheless, primary health care professionals considered the guidelines not applicable to primary health care settings. It could be argued that this stance emerged from agent interactions

following James' death which directed action toward hospital settings and unintentionally suspended action in primary health care.

4.4.7 Competing discourse: General practitioner dissent

In 2002, the guidelines were endorsed by a number of health and social organisations, but notably excluded the Royal New Zealand College of General Practitioners a leading professional body of GPs (Fanslow, 2002). The Royal New Zealand College of General Practitioners declined to endorse both the 2002 and the refreshed 2016 guidelines due to a concern that

The Guideline is aimed at secondary care which sees only a small portion of those with family violence as an issue, and where doctors are largely uninvolved in programme implementation. [...] We know that 80% of women and families are seen in general practice every year, and primary care doctors and nurses have the skills and opportunity to routinely enquire in the context of a safe and trusted environment and relationship (Ministry of Health, 2017b, p. 26).

In 2003, the Royal New Zealand College of General Practitioners led the publication of a general practice 'resource' for responding to IPV (F. Clark, 2003; Ministry of Health, 2003).

Although not indicated in print, the resource was adapted from the 2002 guidelines to be general practice relevant, providing a practical toolkit of knowledge and skills to support IPV responses in practice, alongside training (Healy, 2018b). As such, the resource functions as an educational point of reference for responding to victims of violence, rather than a protocol. The Ministry of Health contracted Medical Sexual Assault Clinicians Aotearoa (an expert body in sexual assault/abuse medicine) to deliver training to GPs and practice nurses, referencing both the 2002 guidelines and the general practice resource (MEDSAC, 2017). However, due to a lack of supporting infrastructure (e.g. a dissemination strategy), delivery of training was limited to interested primary health care audiences (Healy, 2018a). In contrast, hospital settings received ongoing nationally standardised training sessions, which increasingly became mandatory for District Health Board clinicians, following the launch of the Violence Intervention Programme in 2007 (Koziol-McLain, Garrett, & Gear, 2009). The lack of endorsement of what became a foundational piece of the health system response to family violence served to further limit the

participation of primary health care as the health system response moved into an implementation phase.

4.4.8 Reinforcing discourse: The Violence Intervention Programme

The Violence Intervention Project was pilot tested in four hospital settings, between 2002 and 2007, fulfilling the third implementation objective set in 2001. The pilot sites were selected based on the involvement of those who were championing the Violence Intervention Project to date (including the District Health Board cited in the death of James Whakaruru) (Koziol-McLain, 2018). This method created a significant, though unintended, gap as no primary health care pilot sites were included (Koziol-McLain et al., 2006). In 2007, following significant progress by the pilot sites, the Violence Intervention Project was formally launched by the Ministry of Health as the Violence Intervention Programme supported by Vote Health funding (Koziol-McLain, Adams, Garrett, & Sharma, 2007; Koziol-McLain et al., 2009; New Zealand Cabinet, 2007). Following the District Health Board Toolkit, the Violence Intervention Programme was premised on a standardised systems approach seeking to “reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services” (p.1) (Koziol-McLain et al., 2009, p. 1). Implementation of the 2002 guidelines (not endorsed by the Royal New Zealand College of General Practitioners) was central to the programme, supported by nationally standardised training for hospital settings, District Health Board family violence coordinators, resources, technical advice and national networking (Koziol-McLain, Garrett, & Gear, 2011). Uniquely, the Ministry of Health commissioned a comprehensive external longitudinal evaluation of the Violence Intervention Programme, led by the Auckland University of Technology Centre of Interdisciplinary Trauma Research (Gulliver et al., 2018). Evaluation reports functioned to provide District Health Boards and the Ministry of Health detailed implementation information nationally, contributing significantly to the direction of the health system response to family violence (Fanslow et al., 2016). However, despite the Violence Intervention Programme aim of work across District Health Boards (inclusive of primary health care settings), service delivery and evaluation was contracted to six target settings: emergency, child health, maternity, sexual

health, mental health and alcohol and drug (Koziol-McLain et al., 2011). This directed the focus of implementation to those services, creating a gap in other services such as primary health care. The continued use of the term District Health Board, served to obscure the absence of work occurring in primary health care settings (Healy, 2018b).

The Violence Intervention Programme evaluation was also limited in measuring work within primary health care. The partner abuse audit tool used to measure implementation was modified from a United States tool designed to measure hospital-based domestic violence programmes that did not include indicators for primary health care (Centre for Interdisciplinary Trauma Research, 2011; Coben, 2002). While early evaluation reports reflect the Violence Intervention Programme intention to include GPs in training (Koziol-McLain et al., 2006; Koziol-McLain et al., 2004), further information on this work is not given in reports from 2007 onward, suggesting a lack of engagement from either the Violence Intervention Programme, GPs or both. Nevertheless, evaluation reports consistently noted the need to include primary health care settings to achieve family violence prevention targets (Koziol-McLain et al., 2006; Koziol-McLain, Adams, et al., 2007; Koziol-McLain et al., 2004; Koziol-McLain et al., 2009, 2011; Koziol-McLain & Gear, 2012). In 2012, it was noted that primary health care family violence programmes were being introduced opportunistically in some District Health Board regions (Gear et al., 2016; Koziol-McLain & Gear, 2012). However, the contract for, and design of the Violence Intervention Programme evaluation prevented this work being captured, limiting an understanding of responses to family violence within the primary health care sector. Primary health care participation in the health system response was further challenged with the election of a new government.

4.4.9 Event: A change in political ideology

In 2008 the population health approach was diluted by a newly elected government that sought to improve health service performance through an ‘investment approach’. Applied more widely than health care, the investment approach uses data to decide which public services provide longer term returns on investment (Cook, 2016). For health care, the investment approach uses data to fund services that perform well with the rationale that we may then better respond to

high-need populations to avert even higher long term costs (Minister of Health, 2016a, p. 19). This created a heavy focus on achieving a select few health system targets instead of enabling agents to identify and respond to population needs and risks (Matheson & Loring, 2011). The investment approach seriously limited the ability of general practice to innovate responses to health issues beyond the target foci (Gear et al., 2016). The shift to the investment approach was heavily criticised as short-sighted (Ashton & Tenbensen, 2012; Matheson & Loring, 2011), as a weak population health focus unintentionally marginalises primary health care (essential to delivering population health) increasing potential for health inequity (Gauld, 2016; Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015). As responding to family violence was not a health target, the new performance approach to health care undervalued and indirectly undermined primary health care agent interactions seeking to progress responsiveness.

4.4.10 Competing discourse: Supporting a primary health care family violence response

The gap in knowledge and support for a primary health care response was initially identified in 2005 (Adams, 2005). In 2008, the Ministry of Health provided Violence Intervention Programme evaluation funding to develop an evaluation tool to guide family violence responsiveness in primary health care settings (Centre for Interdisciplinary Trauma Research, 2010; Gear et al., 2012). The Centre of Interdisciplinary Trauma Research modified a United States primary health care quality assessment tool for the NZ context and piloted it within six volunteer primary health care sites (Gear et al., 2012; Zink & Fisher, 2007). Following the Violence Intervention Programme, the tool advocated for a systems approach to support primary health care settings in implementing family violence intervention practices (Gear et al., 2012). The tool was made freely available, though no resources to support implementation (i.e. funding) were provided and dissemination to primary health care audiences was limited.

In 2012, capitalising on building momentum in the sector and the evaluation tool, the Centre of Interdisciplinary Trauma Research, utilising additional funds provided by Ministry of Health, hosted a meeting for primary health care professionals interested in developing a formal response to family violence. Delegates formed a National Network that developed five recommendations to progress family violence responsiveness in primary health care. The report

of the meeting emphasised a critical need to support the growing momentum of primary health care professionals responding to those experiencing family violence. However, a government-directed focus on specific health targets, a lack of Ministry of Health funding and appointed leadership for responding to family violence within primary health care and no linkage to policy advocacy within Ministry of Health meant the report remained unpublished, limiting its influence within the sector.

Alongside the National Network, the Centre of Interdisciplinary Trauma Research led a follow-up evaluation of three of the six original pilot sites in 2012 (Gear et al., 2016). Given the limited understanding of how to integrate responses to family violence within health care systems internationally, the published findings shared the experience of pilot site development, demonstrating the challenge of implementing a complex intervention within a complex setting. Notably, each of the pilot sites had successfully acquired fixed-term funding to support response development (Gear et al., 2016). The manuscript strongly supported a systems approach to family violence responsiveness, shaped by the use of the evaluation tool as well as the simultaneous effective implementation of the Violence Intervention Programme. It proposed the use of complexity theory to explore why quality improvement methods (i.e. the evaluation tool) may effect minimal change (Gear et al., 2016). Nevertheless, the new investment approach to health care blocked the progress of these initiatives.

4.4.11 Competing discourse: Responsiveness to Māori

In 2013, the Māori Reference Group for the Taskforce for Action on Violence within Families (2009, 2013) published the second E Tu Whānau: Programme of Action for Addressing Family Violence (E Tu Whānau). E Tu Whānau is a key policy document addressing issues of violence for Māori who, as a colonised population are over-represented in poor social and health outcomes, including family violence prevalence and deaths (Wilson, 2016). E Tu Whānau provides a framework for government and Māori to work together to improve outcomes for Māori over a five-year period. As a guiding document, E Tu Whānau functions to articulate and formalise the belief that Māori can successfully address violence within whānau utilising Māori strengths, opening space for Māori to lead design and implementation of their own solutions to

violence (Dobbs & Eruera, 2014; Te Puni Kōkiri, 2010; The Māori Reference Group for the Taskforce for Action on Violence within Families, 2013). In 2010, the Ministry of Health provided additional funding and resources to improve Violence Intervention Programme responsiveness to Māori (Jigsaw & Ministry of Health, 2014; Koziol-McLain et al., 2011). However, we did not find an indication of interaction between E Tu Whānau and the Violence Intervention Programme within policy or strategy documents. How E Tu Whānau shapes policy and practice for family violence responsiveness within primary health care remains to be seen.

4.4.12 Constructing discourse: Reframing the approach

In 2014, a cross-government package to reduce family violence and a Ministerial Group on Family Violence and Sexual Violence were established (Key, Tolley, Turia, & Collins, 2014; Ministerial Group on Family and Sexual Violence, 2014). The Ministerial Group was tasked with leading a work programme to “achieve an integrated system for preventing and responding to family and sexual violence” involving all agencies, led by Ministers of Justice and Social Development (p.3) (Ministerial Group on Family and Sexual Violence, 2014, p. 3).

Concurrently, the Family Violence Death Review Committee, tasked with investigating how to reduce the number of family violence deaths, published their fourth annual report (Family Violence Death Review Committee, 2014). Alongside other recommendations, the fourth report added to the momentum in the primary health care sector, specifically highlighting GPs as a consistent and frequent point of contact for families over time and recommending GPs as one of three professional groups in need of education and training. The report also encouraged the extension of the Violence Intervention Programme within primary health care (Family Violence Death Review Committee, 2014). Drawing on this support, the Royal New Zealand College of General Practitioners cited the Family Violence Death Review Committee report as evidence in their decision to decline endorsement of the 2016 guidelines (Ministry of Health, 2017b). At the same time, the Family Violence Death Review Committee published their fifth report proposing a new ‘Integrated Safety System’ recommending a nationally funded systems approach to the Violence Intervention Programme within primary health care (Family Violence Death Review Committee, 2016, p. 67). Notably, the Family Violence Death Review Committee’s work was

not reflected within the ‘refreshed’ Health Care Strategy (2016) which does not specifically address family violence (Minister of Health, 2016a, 2016b). It was also not reflected in the revised 2016 Royal New Zealand College of General Practitioners quality standards for general practice. Participating in “health sector family violence programmes” is included in the standards as an “advanced and aspirational-only indicator” that high-performing general practices may use to voluntarily develop their services (p.170) (The Royal New Zealand College of General Practitioners, 2016a, p. 170).

In 2017, the Ministerial Group published a Family Violence Risk Assessment and Management Framework alongside a Family Violence, Sexual Violence and Violence within Whānau: Workforce Capability Framework (Ministry of Justice, 2016; Ministry of Social Development, 2017). These documents seek to establish a common and consistent approach to family violence across all agencies, services and practitioners as well as a minimum base level of provider knowledge, skills and behaviour needed to respond effectively to those experiencing violence. The documents position health care providers as a ‘generalist agency’ that as a ‘primary responder’ is tasked with identifying or responding to a disclosure of family violence and facilitating access to services who can help. Notably, the Risk Assessment and Management Framework only requires health professionals to identify and refer family violence, and excludes risk assessment and safety planning, arguably a large practice gap in an effective and sustainable primary health care response (Gear et al., 2017; Hegarty & O’Doherty, 2011). When consulted on the development of the Risk Assessment and Management Framework in 2016, The Royal New Zealand College of General Practitioners advocated that ‘the health sector should be leading (or at least much more involved in) this work, and that GPs must be included throughout its continued development’ (The Royal New Zealand College of General Practitioners, 2016b). Fortunately, the Ministerial frameworks are considered foundational and are intended to be adapted over time (Ministry of Justice, 2016; Ministry of Social Development, 2017). One could argue that the intent of these documents to implement a common and consistent approach across agencies is the most prominent sign of progress on the pathway initiated by the 1996 Government Statement of Policy on Family Violence and the 1998 guidelines. Despite efforts to redirect the system to be more responsive, the minimal

inclusion of health care in the cross-government package to reduce family violence suggests patterns of interaction between agents have not shifted sufficiently to allow emergence of a dominant discourse promoting health care responsiveness to family violence, particularly within the primary health care sector. Strongly competing discourses function to block sustainable and effective primary health care responses to IPV.

4.5 Discussion

Integrating an effective and sustainable response to IPV has proven a persistent and complex problem for health systems and settings internationally (Garcia-Moreno et al., 2015; Gear et al., 2016). Over the last two decades primary health care in NZ has consistently been identified as a priority setting where disproportionate numbers of people experiencing IPV may present. Yet the sector continues to be under-utilised in the work to reduce family violence, diminishing potential for a whole health system approach to family violence. Complexity theory has enabled us to explore what affects a sustainable response to IPV within NZ primary health care settings. Reconceptualising the research problem as a complex adaptive system calls attention to how interaction between system agents with these documents leads to the emergence of discourse influencing IPV responsiveness. We analysed the function(s) of different policy, strategy, guideline and evaluation documents to map out how these patterns of interaction have self-organised in a way which limits the participation of primary health care in the health system response to IPV. Our analysis emphasised system gaps, unintended consequences and implications for establishing a whole system approach to family violence across both secondary and primary health care.

In particular, we call attention to three system interactions which are currently challenging a sustainable response to IPV in primary health care. First, health care responses to IPV are consistently situated within a public health approach, tasked with preventing the adverse health effects of violence (World Health Assembly, 1996). However, since the Health Strategy 2000, IPV has not been recognised as a determinant of ill-health within key documents that guide health care service delivery (Ministry of Health Manatū Hauora, 2000). The absence of the Violence Intervention Programme within primary health care amplifies this gap for

primary health care professionals. This manuscript illustrates the lack of consistency across system agents in recognising IPV as a key determinant of ill-health over time.

Second, and related to the first, is the absence of policy directive requiring primary health care professionals to respond to IPV as a determinant of ill-health. Political commitment and leadership of the issue is necessary to ensure meaningful change, adequate funding and system coordination (Briones-Vozmediano et al., 2015; Garcia-Moreno et al., 2015; Gear et al., 2016). This manuscript illustrates how shifts in political ideology, e.g. from population-based health to an investment approach, curbed agent ability to respond to health issues outside of health target foci. It also curbed political and policy leadership of the issue, stalling use of the evaluation tool and the momentum of the National Network. Recognition of IPV as a determinant of ill-health is needed within health policy despite health system governance preferences.

Third, is a lack of engagement at both organisational (such as the Royal New Zealand College of General Practitioners) and individual GP and practice nurse levels. NZ GPs hold a unique position in the health system, independent of public governance. This means despite political leadership, GPs are able to circumvent system hierarchy by adapting policy directives through implementation (Tenbenschel, 2016). This manuscript illustrates the ongoing GP opposition to Ministry of Health guidelines and associated training deemed inappropriate for, or unendorsed by, primary health care. Yet, by omission, the analysis also indicates a lack of response by the Ministry of Health to address these issues, and its consequent dampening effect on primary health care participation in the health system response to family violence. Active Ministry of Health engagement with primary health care professionals appears needed to understand how responding to IPV in primary health care occurs, along with GP engagement to promote IPV as a determinant of ill-health.

This manuscript applied an innovative methodology to facilitate new understandings of a persistent and complex problem. However, our data set was limited by its focus on documents that directly influenced IPV responsiveness in health care, omitting wider influences such as community responsiveness or gender equality. Further, analysis of interactions between agents was limited by a largely static view of the complexity provided by documents we selected

within our study boundaries. Although complexity theory is useful in eliciting the complexities of the problem, it also means that interpretation will vary depending on the context in which they are read. We sought to call attention to agent interactions to open discussion on what they mean and how we might manipulate them to increase IPV responsiveness. Our next steps are to analyse interview data from front-line primary health care professionals on what occurs in practice. Combining these data sources will provide rich and diverse data in which we may explore and test for agent interaction pattern consistencies and inconsistencies that challenge or promote sustainable responses to IPV.

4.6 Conclusions

Our use of complexity theory contributes an innovative perspective of an internationally complex problem. Yet this is only one part of the complexity involved in implementing sustainable health care responses to IPV. Our implementation narrative exemplified the nature of sustainability as continuously emerging from the interaction between system agents, known or unknown. However, our analysis called attention to three system interactions critical to engaging the whole health system in responding to IPV. There is potential to intervene in these interactions to nudge the system in the desired direction, i.e. address IPV as a determinant of ill-health, establish a policy directive to respond to IPV, and engage with the primary health care sector to promote IPV as a determinant of ill-health. NZ holds a leading international role on responding to family violence in health care. Given the complexity of developing and implementing sustainable health care responses to IPV, this manuscript contributes valuable insights for the international health care community involved in responding to IPV.

4.7 List of Abbreviations

IPV: Intimate Partner Violence; RNZCGP: Royal New Zealand College of General Practitioners; MEDSAC: Medical Sexual Assault Clinicians Aotearoa; E Tu Whānau: E Tu Whānau: Programme of Action for Addressing Family Violence.

4.8 Endnotes

^a IPV is but one part of violence within familial relationships which we refer to as family violence. ^b Indigenous people of New Zealand.

Chapter 5 Health Professional Triple R Pathways

To explore health professional responses to IPV in practice, I interviewed 17 primary care professionals across four general practices on IPV as a health issue. Identifying the function of health professional narratives proved more difficult than for document analysis. Ultimately, it involved understanding how health professional responses to IPV were influenced by interaction with the contexts they worked within. From this perspective, I was able to see *what* the health professional thought and *how* that was a product of their interaction with their contexts. This led to an understanding of *why* they conveyed what they did, the function of the narrative.

The ‘Triple R Pathway’ emerged from the complexity-led analysis of interview data. This complex adaptive system approach provides the means to explore how variable IPV responsiveness occurs and how we might intervene to promote sustained responsiveness. In this chapter I present the Triple R Pathway of each interview participant, describing how a participant *Respond* stance influences how a *Response* may be conceptualised impacting on *Responsiveness*. This pathway is fully articulated in chapter six. The following chapter groups participants by the four general practices with a brief descriptor of each general practice preceding participant pathways. Tables 7, 8, 9, and 10 summarise the participant *respond* stance and *response* discourse.

Please note: If this data is used, there must be appropriate attribution to the author and indication if changes were made. The work may be shared or adapted in any reasonable manner, but not in any way that suggests the author endorses you or your use.

5.1 Whānau Oranga (Family Health)

Whānau Oranga [Family Health] provides accessible low-cost services to whānau using a kaupapa Māori approach. We interviewed seven Whānau Oranga workers: the practice manager, GP, nurse practitioner, practice nurse, administrator, social worker and the associated Primary Health Organisation manager. Across participants, we found the dominant *respond*

stance was about providing for the needs of the people. This generated a diversity of *response* discourses and wide-ranging ways of being *responsive*.

Participants were connected by an environment of complex patient health and social needs and relied on connectivity with community services (e.g. mental health services, financial support) to provide effective care. All seven participants described different ways health system structure prevented the practice from transforming into a more effective model of care. At the time of data collection, inclusion of community services had variable influence on IPV *responsiveness*. The inability to transform to another model of care more effective for their patients, such as Whānau Ora³, meant Whānau Oranga struggled to fulfil their *respond* stance of providing for the needs of the people. The following explores the Triple R Pathway of Rachel, a Nurse Practitioner at Whānau Oranga.

Table 7. 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

³ Whānau Ora is an indigenous health initiative driven by Māori cultural values. It aims to empower whānau [family] within a community context rather than individuals within an institutional context.

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 that 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 āhua⁴ [*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."

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 whenua⁵ 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

⁴ Āhua denotes the character of the person.

⁵ Tangata whenua are the people of the rohe, the land or region where they are born.

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 that 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 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 utilise 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 that 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 that seeks to redefine health within a kaupapa Māori⁶ 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.

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.

⁶ Kaupapa Māori is a philosophy which incorporates the knowledge, skills, attitudes and values of the Māori world.

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.

5.2 Family Care Practice

Family Care Practice provides care to a general, mid-to-high socio-economic patient population. We interviewed three Family Care Practice workers: a practice manager, practice nurse and general practitioner. Across the participants, we found the dominant *respond* stance was ‘we can do better’. Both the practice nurse and the GP were *responsive* when they encountered violence and were willing to put systems and processes in place. However, known options available to address IPV were missing at Family Care Practice constraining *responsiveness*.

The willingness to address IPV had not reached practice management, which was largely focused on achieving top down directives to ensure business survival. The practice manager held a competing *response* discourse of ‘it’s [responsiveness] probably happening anyway’, suggesting no further action was needed. The invisibility of IPV as a health issue at the health system level supported this competing discourse, both contributing to a lack of workplace support and diminishing frontline voices, a negative feedback loop. The assumption health professionals could effectively address IPV with existing skills had an effect of isolating the GP and practice nurse who felt they could be doing better. The following explores the Triple R Pathway of Anna, a GP at Family Care Practice.

Table 8. 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

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 that 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*.

5.3 Te Whānau Hauora (The Family Health)

Te Whānau Hauora [The Family Health] provides care to a local, largely low-to-mid socio-economic Māori community, focusing on health promotion and regular access to a GP. We interviewed three Te Whānau Hauora workers: practice manager, GP, and associated Primary Health Organisation manager. Across the participants, we found the dominant *respond* discourse to be 'we have to engage differently'. This generated a dominant *response* discourse that acknowledged a wide range of complexities involved in addressing IPV.

The relationships between the participants were very loose. The Primary Health Organisation manager and practice manager shared an understanding of IPV as inherently connected to socio-ecological determinants. The GP was reluctant to address IPV presentations and had only recently formed his narrative of IPV as a health issue. The following explores the Triple R Pathway of Hana, the practice manager of Te Whānau Hauora.

Table 9. 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 that 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 that 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 that 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 that 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*.

5.4 First Medical Care

First Medical Care provides care to a general, mid-to-high socio-economic patient population. We interviewed four First Medical Care workers: a practice manager, GP and two practice nurses. Across participants, we found the dominant *respond* stance, largely based on personal views, recognised IPV as an area not adequately addressed by First Medical Care. However, the dominant *response* discourse was IPV is not a problem for their patient population, that there is no 'clinical need'. A focus on top down directives coupled with the absence of IPV recognition at the health system level reinforced this *response* discourse. It generated a paucity of knowledge on IPV as a key determinant of ill-health contributing to participant doubt of what to do. Competing *response* discourses were held by the practice nurses who were proactively *responsive*. Yet the dominance of the overall *response* discourse diminished their voices and generated system barriers that constrained their *responsiveness*. Like Family Care Practice, the *response* discourse of First Medical Care perpetuated a negative feedback loop obscuring IPV across system levels. The following explores the Triple R Pathway of Mike, the practice manager of First Medical Care.

Table 10. Participant *respond* stance and *response* discourses

Participant	<i>Respond</i>	<i>Response</i>
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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), that 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 that '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' that 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' that guides 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.

Chapter 6 A profound system gap: Sustainable primary care responses to intimate partner violence

6.1 Prelude

I began this study interested in how wider system structures shape understanding of, and responses to, IPV. As illustrated in Chapter five, responsiveness to IPV within clinical interactions varies widely within the NZ primary care sector. I met health professionals who were passionate about responding to family violence, some who did not consider it an issue for their patients, and others who consciously deflected or ignored it. This chapter follows chapter five by describing the complex adaptive systems approach, the 'Triple R Pathway' that emerged from exploring primary care professional discourses on responding to IPV as a health issue.

Journal restrictions on word count meant I could not include all seventeen participant Triple R Pathways in a manuscript. Instead, four exemplars of the Triple R Pathway are provided. These exemplars are used to call attention to two key system interactions working to block the emergence of sustainable IPV responses: 1) recognising IPV as a health issue and 2) doubt and engaging with uncertainty. I recommend ways we may intervene to alter the system pathway so future health professionals and care-seekers are not trapped by the same system interactions.

The final section of this chapter also presents findings I was not able to include within the manuscript. In this section, I bring together the document and interview data sets and call attention to two further system interactions related to implementation. I show how complexity theory enhances implementation by calling attention to contextual influences. The following manuscript titled *A Profound System Gap: Sustainable Primary Care Responses to Intimate Partner Violence* has been submitted for publication.

6.2 Introduction

Intimate partner violence (IPV) is a global public health problem of epidemic proportions (Garcia-Moreno et al., 2015). It is also known as a complex problem, recognising the myriad of entangled factors which contribute to, and sustain, violence in people's lives (Young-Wolff et al., 2016). Despite a considerable body of research, integrating effective and sustainable responses to IPV has proven challenging internationally. The best evidence-based practice is still unknown and little progress has been made on the frontline (Garcia-Moreno et al., 2015). At a minimum, health professionals should provide a first-line response involving facilitating disclosure, offering support and referral, providing medical treatment and follow-up care and documenting evidence (World Health Organisation, 2013b).

Complexity theory is a useful heuristic for viewing a problem in a different way (D. S. Thompson et al., 2016). It allows reconceptualisation of health care systems as complex adaptive systems, with a focus on how interactions between system elements co-evolve and self-organise into new behaviours. Over time, these behaviours can lead to new system structures (R. R. McDaniel & Driebe, 2001). In New Zealand (NZ), complexity theory has been usefully applied to study the systems involved in responding to family violence (Family Violence Death Review Committee, 2014; Gear et al., 2018b).

The NZ health system response to family violence largely lies within the Ministry of Health Violence Intervention Programme, responsible for identifying, assessing and referring those experiencing IPV or child abuse and neglect. The programme has successfully established infrastructure to support health professional responses in hospital and selected community settings, yet, service consistency and quality remain suboptimal (McLean et al., 2018). Further, engagement with the primary care sector has been limited (Gear et al., 2018b; Gear et al., 2016).

Internationally, primary care is known as a setting which is likely to encounter persons with signs and systems of violence. It is a consistent point of contact for families and a service those living with violence choose to engage with (World Health Organisation, 2013b). Yet, often unknowingly, health care professionals will treat the sequela of violence without addressing the cause (Garcia-Moreno et al., 2015). Clinicians often do not recognise the signs and symptoms of violence and lack confidence in asking (Elvidge, 1996; Taft et al., 2011). Two

decades ago in NZ, general practitioners (primary care doctors; GPs) reported being concerned they were working ineffectively by missing cases of IPV, or intervening poorly (Elvidge, 1996).

Utilising complexity theory, we sought to understand what affects a sustainable response to IPV within NZ primary care settings. We hypothesised an effective and sustainable response will emerge when interactions between the care-seeker and primary care generate mutual benefits (e.g. reduced violence and health professional confidence) (Gear et al., 2017). This manuscript presents the ‘Triple R Pathway’ that emerged from exploring primary care professional discourses on responding to IPV as a health issue. We provide four exemplars of how the Triple R Pathway calls attention to system interactions influencing responsiveness to IPV. Two key system areas that challenge primary care responses to IPV are discussed alongside ways to intervene to promote the emergence of sustainability. The authors understand IPV to be a pattern of cumulative harm that overwhelmingly impacts women and children (Family Violence Death Review Committee, 2016). While we focus on IPV, the term family violence may be also used, recognising the extended nature of harms.

6.3 Methods

Grounded in poststructuralism, we applied complexity theory as a qualitative research methodology, guiding our choice of theoretical perspective, research question, methodology and methods (Gear et al., 2018a). Ethical approval was granted by the Auckland University of Technology Ethics Committee (Ref 17/31). See Appendix A Ethics approvals.

6.4 Setting and recruitment

The study was conducted within a region of the North Island of NZ. We sought to recruit four general practices; two serving a general patient population and, in recognition of the NZ Tiriti o Waitangi⁷, two adopting a kaupapa Māori⁸ approach for the indigenous Māori population. Collecting multiple health professional data within four settings allowed for sample diversity and confidence in the findings. The primary researcher (CG) worked to build relationships in

⁷ Tiriti o Waitangi [the Treaty of Waitangi] is the founding document of New Zealand. It is an agreement between the British Crown and Māori chiefs.

⁸ Kaupapa Māori is a philosophy which incorporates the knowledge, skills, attitudes and values of the Māori world.

the field to recruit participants. Using a snowball sampling technique, recruitment took place till selection criteria were met. Seventeen of 43 practices in the region were initially approached to recruit the four practices. Practices declined to participate due to capacity restrictions, absence of interest, not recognising IPV as an issue for patients or claiming no knowledge to contribute. Others were already participating in other research studies, undergoing restructuring or did not provide a reason. Practices agreed to participate due to interest in the issue and researcher-developed relationships.

Across the four recruited general practices, 19 health professionals were invited to participate in a 30-minute interview on IPV as a health issue, including four practice managers and two managers representing the associated Primary Health Organisations. Two participants declined to participate, one due to lack of interest and the other provided no reason. An agreement with participating general practices and health professionals specified confidentiality, preventing detailed reporting of participant characteristics, such as age and ethnicity, see Table 7.

Table 11: Participant characteristics

Gender	3 men, 14 women
Roles	Practice manager, Primary Health Organisation manager, General practitioner, Practice nurse, Nurse practitioner, Administrator, Social worker

Written consent was obtained from the practice manager at each general practice and recorded verbal consent from health professionals. Participants were offered a \$50 supermarket voucher to compensate for any costs incurred by participating and assured they would not be asked about IPV experiences, either patient-related or personal. Help-seeking advice was included in the participant information sheet. See Appendix B Final participant information sheets and consent forms.

6.5 Data collection

Interviews, conducted by a skilled researcher, were audio-recorded. Interviews ranged from 30-70 minutes and were conducted in private at locations convenient to the participant, mostly the workplace. A dynamic interview guide was developed, informed by concurrent document analysis and designed to identify and explore discourses influencing responses to IPV. This was

revised after five interviews to address a concern data tended towards health system complexity, rather than the complexity of responding to IPV. The revised guide was unstructured and conversational, to better elicit response diversity and complexities. See Appendix C Interview Questions.

6.6 Data analysis

Primary analysis was conducted by the interviewer with discussion among all authors. Informed by Morse, Barrett, Mayan, Olson, and Spiers (2002), rigour was maintained through verification and researcher responsiveness. Interviews were transcribed and audited using Dragon (Nuance Communications) and uploaded to NVivo (QSR International). Analysis occurred in three phases, responsive to what emerged from the data. First, interviews were coded for broad areas of ‘talk’. Code names and descriptions used participant words to offset data reduction. A second coding round checked for misunderstanding and validity. 200 narrative strings reflecting organisational discourses were found, consistent with the research aim of maintaining diversity.

Second, narrative analysis was applied to explore deeper into each of the codes. Individual narratives were developed to preserve the diversity and context of each individual. Narratives were analysed for ‘small stories’ to capture the diverse ways the narratives were constructed and shaped by different contexts (De Fina & Georgakopoulou, 2011). The small stories were analysed for their function - what message(s) did the participant intend to convey - supported by narrative analysis questions derived from De Fina and Georgakopoulou (2011). For each participant a key narrative, or dominant discourse emerged from the analysis.

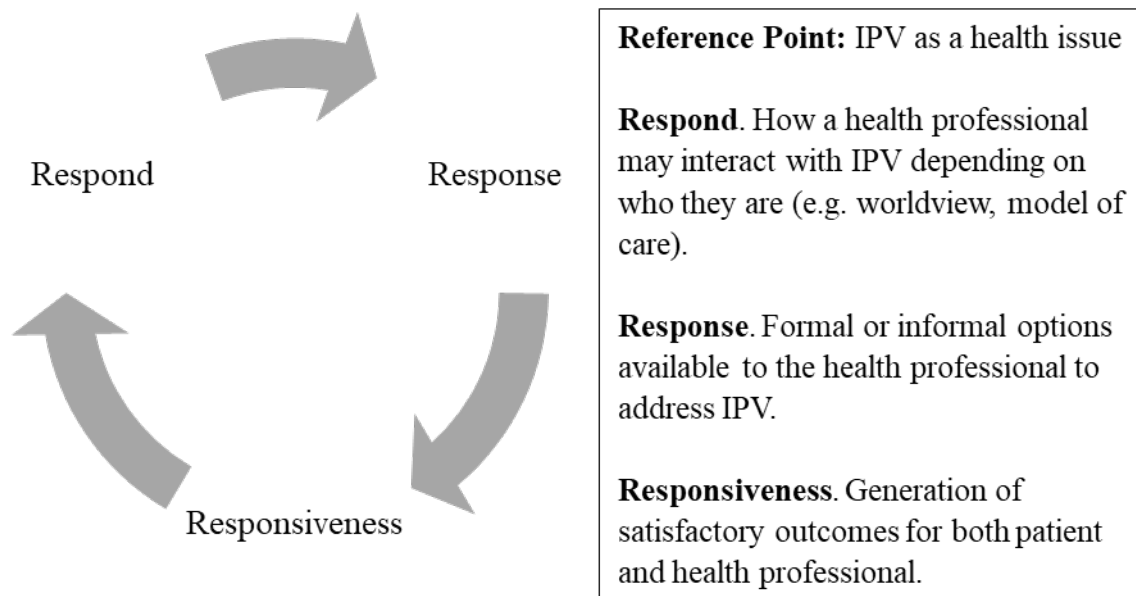
Third, complexity analysis was applied by viewing each participant narrative as a complex adaptive system using the complexity concepts of interaction, co-evolution, self-organisation and emergence. We explored what patterns of interaction led to the dominant discourse and how interactions self-organised to influence health professional practice. A pattern emerged where who the participant was shaped how they conceptualised an IPV response which, in turn, influenced how responsive to IPV they could be. We named this pattern the ‘Triple R Pathway’ and successfully tested the pattern on the 17 participant narratives by developing complexity-led narratives mapping individual Triple R Pathways. In the following

section we describe the Triple R Pathway before demonstrating its use with a selected participant exemplar from each general practice.

6.7 Findings: The Triple R Pathway

Analysis exposed multiple meanings of an IPV response where individual and organisational discourses are competing for dominance. Emergent from analysis, the Triple R Pathway is a complex adaptive system approach that calls attention to system interactions influencing responsiveness to IPV in primary care across clinician, general practice and health system levels (Figure 2). It demonstrates how health professionals and health care organisations self-organise to be responsive, or unresponsive to patients experiencing or perpetrating IPV.

Figure 2: The Triple R Pathway



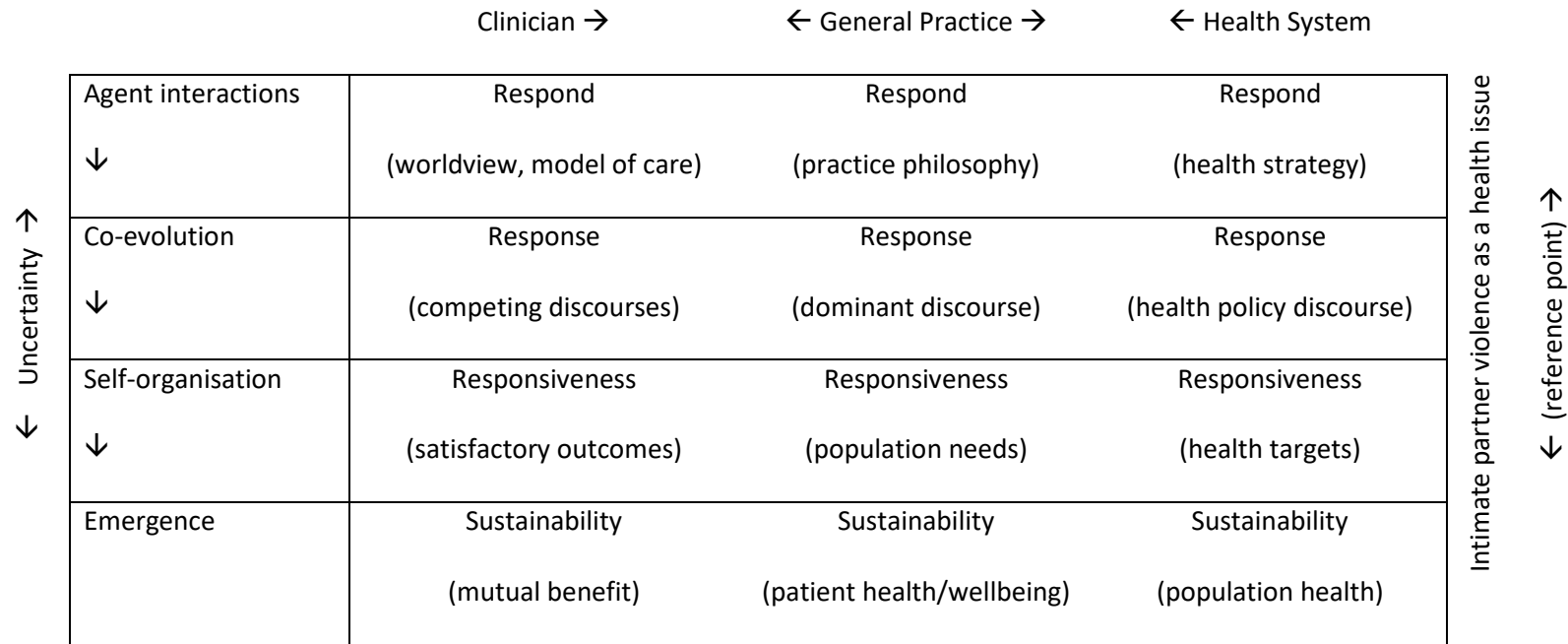
How a health professional may *respond* to IPV is influenced by the individual's worldview, philosophy, or model of care. This sets a path-dependency (how history influences current behaviour and events) for how a professional may interact with a person experiencing or perpetrating IPV (Gear et al., 2018a). For example, a health professional that views IPV as a problem for a particular social or ethnic group may be less responsive than a patient-centred practitioner who views each patient as different. The individual's *respond* stance shapes what formal or informal *responses* a health professional may conceptualise, including doing nothing.

A *response* discourse is generated in relationship to an individual's understanding of IPV as a health issue (interview reference point). That is, how they understand IPV as a health issue influences how they think of a *response*. For example, if IPV is unrecognised as a health issue, a *response* discourse and *responsiveness* become non-existent. Competing discourses may view the reference point differently, influencing *response* discourses.

How *responsive* a health professional may be is the self-organisation of multiple, diverse and nonlinear system interactions along this path, including interactions with those living with violence. Patterns of interaction along each part of the pathway, *respond*, *response*, *responsiveness*, self-organise to generate *responsiveness*. For example, an unexpected disclosure may prompt the health professional to seek better *response* resources, improving their *responsiveness* and altering their *respond* stance. Alternatively, an encounter that leads to further harm may alter the *respond* stance (less confidence) restricting the *response* discourse (do not engage), leading to reduced *responsiveness*. Each part of the pathway is dynamic, constantly interacting with and within each other.

Figure 3 depicts the Triple R Pathway across clinician, general practice and health system levels. Viewed horizontally, the figure shows how interactions between levels co-evolve. Viewed vertically, the figure shows how system interactions within each level co-evolve, leading to self-organised responsiveness. Sustainable responses to IPV will emerge when these patterns of interaction repeat to form a positive feedback loop at each level.

Figure 3: The Triple R Pathway across system levels



To demonstrate the use of the Triple R Pathway we provide a participant exemplar from each general practice. Each section begins by briefly describing interactions occurring within the general practice before exploring the exemplar. Participant *respond* stances and *response* discourses are summarised in Table 8, and their influence on *responsiveness* is discussed below. Pseudonyms replace participant and organisation names.

Table 12: Four exemplar *Respond* stances and *Response* discourses

General Practice	Participant	Respond stance	Response discourse
Whānau Oranga	Rachel, Nurse Practitioner	I just want to make a difference	Making sure I know what to do
Family Care Practice	Anna, General Practitioner	It's a big problem unrecognised for its importance	I just need to do it
Te Whānau Hauora	Hana, Practice Manager	We engage differently with whānau	It just doesn't happen like that
First Medical Care	Mike, Practice Manager	IPV is a human rights violation	We need an effective and consistent process

6.8 Whānau Oranga

Whānau Oranga [Family Health] provides accessible low-cost services to whānau using a kaupapa Māori approach. We interviewed seven Whānau Oranga workers: the practice manager, GP, nurse practitioner, practice nurse, administrator, social worker and the associated Primary Health Organisation manager. Across participants, we found the dominant *respond* stance was about providing for the needs of the people. This generated a diversity of *response* discourses and wide-ranging ways of being *responsive*.

Participants were connected by an environment of complex patient health and social needs and relied on connectivity with community services (e.g. mental health services, financial support) to provide effective care. All seven participants described different ways health system structure prevented the practice from transforming into a more effective model of care. At the time of data collection, inclusion of community services had variable influence on IPV *responsiveness*. The inability to transform to another model of care more effective for their patients, such as Whānau Ora⁹,

⁹ Whānau Ora is an indigenous health initiative driven by Māori cultural values. It aims to empower whānau [family] within a community context rather than individuals within an institutional context.

meant Whānau Oranga struggled to fulfil their *respond* stance of providing for the needs of the people. The following explores the Triple R Pathway of Rachel, a Nurse Practitioner at Whānau Oranga.

6.8.1 *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 wasn't comfortable to ask and didn't know what to do about it. This amplified when she began working at Whānau Oranga.

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. [...] It was emotionally taxing, more than I expected.

This environment changed the way she looked at a problem and the way she practiced. Her *respond* stance motivated her to identify people needing help. This was reinforced when she was able to help someone, supported by access to community services, but challenged when poor communication with community services made referral difficult.

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 to [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.

'Just wanting to make a difference' directly, and strongly, influenced 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. 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 influenced her *responsiveness*. Faced with a complex problem, she was motivated to take steps to ensure 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's personal desire to make a difference for people 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. She called attention to the general practice funding model as a main constraint. She believed the practice could become more *responsive*, such as referring patients to community services, but the funding model blocks transformation to a model of care more responsive to the complex health and social needs of their patients. She said, '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'.

6.9 Family Care Practice.

Family Care Practice provides care to a general, mid-to-high socio-economic patient population. We interviewed three Family Care Practice workers: a practice manager, practice nurse and general practitioner. Across the participants, we found the dominant *respond* stance was 'we can do better'. Both the practice nurse and the GP were *responsive* when they encountered violence and were willing to put systems and processes in place. However, known options available to address IPV were missing at Family Care Practice constraining *responsiveness*.

The willingness to address IPV had not reached practice management, which was largely focused on achieving top down directives to ensure business survival. The practice manager held a competing *response* discourse of 'it's [responsiveness] probably happening anyway', suggesting no further action was needed. The invisibility of IPV as a health issue at the health system level supported this competing discourse, both contributing to a lack of workplace support and diminishing frontline voices, a negative feedback loop. The assumption health professionals could effectively

address IPV with existing skills had an effect of isolating the GP and practice nurse who felt they could be doing better. The following explores the Triple R Pathway of Anna, a GP at Family Care Practice.

6.9.1 Anna, General Practitioner

Anna's *response* discourse 'I just need to do it', derives from recognition that family violence is a big problem for health care, unrecognised for its importance, her *respond* stance. Anna claims family violence is not discussed enough in health care, believing health professionals find it difficult to talk about because they have not been trained to deal with it and they may not respond well. She describes a situation that 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. 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.

Anna believes it is only when you see victims of violence that you realise how common it is. She advocates for increased understanding and awareness so effective support can be provided straight away making '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. She rationalises people are concerned about what they need to do, how much time it will involve and what referral resources are available. The known prevalence of IPV can also act as a barrier to screening, for fear of a lot of positive responses.

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. 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 knows she must have met people experiencing IPV without realising it. She believes it is about timing for people, asking the right questions and providing an environment where they can talk about it. An open, trusted relationship is key, but she acknowledges it may be helpful to some and not others.

I had a lady who had really bad anxiety, terrible terrible anxiety when I was at [practice]. I started talking basically about that [anxiety] 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 [...] something had triggered it all off again, and she was getting panic attacks and just huge levels of anxiety [...] 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'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, Anna feels like she could do it better. 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.

6.10 Te Whānau Hauora

Te Whānau Hauora [The Family Health] provides care to a local, largely low-to-mid socio-economic Māori community, focusing on health promotion and regular access to a GP. We interviewed three Te Whānau Hauora workers: practice manager, GP, and associated Primary Health Organisation manager. Across the participants, we found the dominant *respond* discourse to be 'we have to engage differently'. This generated a dominant *response* discourse that acknowledged a wide range of complexities involved in addressing IPV.

The relationships between the participants were very loose. The Primary Health Organisation manager and practice manager shared an understanding of IPV as inherently connected to socio-

ecological determinants. The GP was reluctant to address IPV presentations and had only recently formed his narrative of IPV as a health issue. The following explores the Triple R Pathway of Hana, the practice manager of Te Whānau Hauora.

6.10.1 Hana, Practice Manager

Hana's *respond* discourse 'it just doesn't happen like that' is influenced by a strong *respond* stance that her organisation engages with whānau differently to other health care services. She argues a first-line response would be ineffectual as IPV does not present to the hauora¹⁰ in that way. For Hana, IPV occurs because of problems at home, such as unemployment or substance abuse. She says whānau find it difficult to, and are fearful of, asking for help. This is why she seeks to engage whānau differently, in ways which open spaces for people to ask for help for anything, including IPV.

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 and host wānanga¹¹ to provide a space for people to ask for help. Te Whānau Hauora engages with the whole family, recognising suffering affects more than the individual. Hana's *response*, 'it doesn't happen like that', continually reinforces her *respond* stance, 'we must engage differently' and vice versa. She illustrates why engaging differently is important.

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*. She says it is the hauora that supports the family, by 'picking up 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.

¹⁰ A clinic based on Māori philosophy of health and wellbeing.

¹¹ Wānanga are discussions to provide education in a Māori cultural context.

Being around friends and other positive family members, going for walks. [...] 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. Her *respond* stance leaves room to co-evolve alongside whānau. For example, she will 'pick up the pieces' whatever they may be. Hana's wide understanding of the complexities involved in responding to IPV as a health issue for whānau initiates a *responsive* Triple R Pathway, however, she remains constrained by health and social systems which generate fear to ask for help.

6.11 First Medical Care

First Medical Care provides care to a general, mid-to-high socio-economic patient population. We interviewed four First Medical Care workers: a practice manager, GP and two practice nurses. Across participants, we found the dominant *respond* stance, largely based on personal views, recognised IPV as an area not adequately addressed by First Medical Care. However, the dominant *response* discourse was IPV is not a problem for their patient population, that there is no 'clinical need'. A focus on top down directives coupled with the absence of IPV recognition at the health system level reinforced this *response* discourse. It generated a paucity of knowledge on IPV as a key determinant of ill-health contributing to participant doubt of what to do. Competing *response* discourses were held by the practice nurses who were proactively *responsive*. Yet the dominance of the overall *response* discourse diminished their voices and generated system barriers that constrained their *responsiveness*. Like Family Care Practice, the *response* discourse of First Medical Care perpetuated a negative feedback loop obscuring IPV across system levels. The following explores the Triple R Pathway of Mike, the practice manager of First Medical Care.

6.11.1 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. He believes NZ has an 'out of control domestic violence situation' and considers current responses 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.

For Mike, consistency is the key to helping people, achieved through policy and protocol. He describes a procedure as the 'steering document' that guides clinician practice. '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.

6.12 Discussion: A profound system gap

The under-utilisation of the primary care sector in preventing and intervening in IPV is a profound system gap for a country dedicated to reducing family violence. NZ leads the world with its health system response to family violence but has failed to engage the primary care sector, internationally recognised as a priority setting. The following discussion draws on our exploration of all 17 primary care professional discourses on IPV as a health issue. We call attention to two key areas where system interactions influence sustainable primary care responses to IPV: (1) recognising IPV as a health issue (2) doubt and engaging with uncertainty.

6.12.1 *Recognising IPV as a health issue*

Internationally, violence prevention within a public health approach is underpinned by a socio-ecological framework demonstrating how determinants intersect across individual (e.g. mental health), interpersonal (e.g. childhood exposure to violence), community (e.g. community disempowerment) and social/structural (gender inequities) levels, contributing to violence (Decker et al., 2018). We found an inadequate understanding of the relationship between primary care and socio-ecological contexts, preventing an understanding of IPV as a key determinant of ill-health. At the clinician level, there was variable recognition and understanding of socio-ecological determinants which contribute to and sustain violence within families. Some participants viewed IPV only as a health issue that should be identified and referred to social services, obscuring relationships with socio-ecological determinants.

How IPV is understood precludes some *response* meanings and not others. We found different understandings generated tensions in practice. For example, in resistance to the public health method, Hana, practice manager of Te Whānau Hauora, took offense to the assumption they would routinely enquire about IPV with patients as this did not reflect who they were as a people. The exclusion of different meanings of a *response* at the health system level obscures relationships with other systems as well as opportunities for integration and collaboration.

Understanding different IPV *response* discourses is particularly important for indigenous peoples whose voices are often unheard (Wilson, Heaslip, & Jackson, 2018). In NZ, Māori experience

significant health, social and economic inequities. A current Tiriti o Waitangi claim on the prejudicial nature of the primary care framework for Māori, specifically highlights the importance of recognising the relationship between social conditions and health status to improve Māori health (Maipi, Moxon, Tapsell, & Paul, 2005; Mason, Royal, & National Hauora Coalition, 2017). We found inadequate recognition of the socio-ecological determinants of IPV for Māori undermines the emergence of Māori mana motuhake (self-determination) and blocks the ability for general practices to transform to models of care more effective for Māori, limiting how *responsive* primary care professionals can be to Māori patients. Expecting Māori to engage in racist health and social systems that perpetuate inequality and inequity is irrational and offensive to both patients and health professionals (Came, 2014).

We found resistance to the inadequate recognition of the relationship between IPV and socio-ecological contexts. For example, a nurse and social worker at Whānau Oranga described how the ‘realities’ whānau live with, such as poverty or gang violence, sustain violence and constrain the ability to ask for help. They strongly believed current health and social resources to address IPV were inappropriate and unhelpful to Māori. This motivated them to deviate from normal practice to ensure the safety of their whānau. For example, the social worker at Whānau Oranga would use her own agency to be there for clients, even if her engagement with them had formally ended.

A negative feedback loop diminishes the voices of the frontline, blocking the need to clinically address IPV being communicated to management. We found most primary care professionals were aware of, and willing to, address the harm of IPV, yet their voices were not reflected at the general practice level and seemingly non-existent at wider health system levels. Absence at the health system level then functioned to constrain *responsiveness* at the clinician level. The Primary Care Working Group on General Practice Sustainability (2015), established to provide the Minister of Health guidance about primary care funding, sustainability and workforce arrangements, also called for the voices of frontline primary care professionals to be listened to more. Frontline advocacy raising IPV as a clinical need could influence this loop.

Despite successive governments prioritising the reduction of family violence, the health care system response has remained inadequate and inconsistent. Currently, recognising IPV as a key

determinant of ill-health is absent within health system policies and strategies (Gear et al., 2018b). We argue the lack of recognition of IPV as a key determinant of ill-health contributes to existing primary care professional perceptions that there is no clinical need to address IPV, that health professionals are already capable, or that health professionals are probably addressing IPV effectively already. It also diminishes the voices of those wanting to address IPV or family violence and limits learning about family violence within general practice, blocking *responsiveness*.

Inadequate recognition of socio-ecological determinants of IPV limits health system response effectiveness. Weak relationships with other contexts allow the health system to restrict its response to addressing the health effects (such as injuries or depression), or simply identify and refer on to community services, without explicitly recognising IPV as a key determinant of ill-health. In practice this means providers are less likely to see the cause behind the symptoms, missing the opportunity to initiate change. As a practice nurse at First Medical Care said, ‘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.’

To respond more effectively to those experiencing or perpetrating IPV and promote system wide change, the health system must widen its approach to understand IPV as a key determinant of ill-health. We need to call attention to how the health system interacts with other contexts regarding IPV, both effectively and ineffectively, utilising the ‘enormous potential for collaboration and joint action between programmes’ (World Health Organisation, 2010, p. 277). Currently, inadequate recognition of IPV as a key determinant of ill-health restricts the ability to be responsive to diverse populations and contexts and reinforces inequity, challenging the emergence of a sustainable health system response.

6.12.2 Doubt and engaging with uncertainty

Many competing IPV *response* discourses generate uncertainty within the complex adaptive system. In practice, this uncertainty manifested as doubt of what to do. Uncertainty arises from the complexity of the problem, the contingent reactions of individual agents in response to unknowns, and a lack of codified knowledge. Begun and Kaissi (2010) define uncertainty as ‘the inability of agents in systems to accurately predict the consequences of an action or the future state of the agent, the system, or the

environment' (p. 110). Often, we try to reduce uncertainty through intentional means such as implementing policy or a standardised intervention. Yet these measures have limited impact due to the unpredictable nature of complex adaptive systems where multiple known or unknown outcomes are possible and will affect the starting point and the trajectory of a response (Begun & Kaissi, 2010; Khan et al., 2018).

Based on complexity theory, the Cynefin Framework sorts issues into five contexts, simple, complicated, complex and chaotic, based on the relationship between cause and effect. The fifth context, disorder, is applied when it is unclear which context the issue falls within (Snowden & Boone, 2007). We consider primary care *responses* to IPV to be occurring within a 'chaotic context' (Snowden & Boone, 2007). The number and nonlinearity of interactions between the complex worlds of the care-seeker and primary care means finding the right solutions, or establishing cause and effect, is very challenging. The chaotic context is further exacerbated by the doubt primary care professionals experience when faced with responding to IPV. Doubt arose from an absence of IPV recognition within the health system (e.g. no health strategy, policy and protocols) and the paucity of knowledge around IPV as a key determinant of ill-health, response options and health and social system navigation (such as referral pathways). Primary care professionals also doubted what others may do in response to their action(s) e.g. patient response.

In contrast, we view the health system response as occurring within a 'simple context' where there are clear relationships between cause and effect and the right answer for the context is known (Snowden & Boone, 2007). Management involves sensing the issue (identify), categorising it (assess) and responding to it (refer) using best, or known, practices (Snowden & Boone, 2007). For example, the Violence Intervention Programme provides infrastructure supporting health professionals to routinely enquire about IPV (Fanslow et al., 2016). The programme seeks to enhance the effectiveness of a response by reducing the uncertainty involved in responding to IPV, i.e. reducing doubt over what to do. Yet, as Goicolea, Hurtig, San Sebastian, Vives-Cases, et al. (2015) found, 'adequate detection of women suffering from IPV is a complex process that requires more than asking questions and following the steps of a protocol' (p. 9). We argue a simple notion of cause and effect at the

health system level, e.g. identifying IPV will lead to improved quality of life (Miller & McCaw, 2019), misaligns with the evident chaotic context of responding to IPV in primary care.

Snowden and Boone (2007) argue looking for patterns in a chaotic context is pointless, rather, we must act to ‘stanch the bleeding’, or establish order (p. 74). This involves sensing where stability is present or absent and working to move the situation into a ‘complex context’ where patterns may be identified (Snowden & Boone, 2007). We found different *respond* stances generated multiple *response* discourses. Working at the policy or system level to reduce uncertainty by fixing or prescribing a *response* will be ineffective as a *response* will be continuously reshaped based on who the person is and how they understand the issue. While Goicolea, Hurtig, San Sebastian, Vives-Cases, et al. (2015) and others argue variability in care based on health professional characteristics is problematic for sustaining and institutionalising responses (Colombini, Dockerty, & Mayhew, 2017; Goicolea et al., 2013), our findings suggest the opposite. Rather than standardising a *response*, engaging with uncertainty at the practice level allows for the emergence of more opportunities for change and improvement.

Positioning the health system response within a ‘simple context’ obscures different ways of being *responsive*. In our empirical data, those who were *responsive* engaged with the uncertainty of IPV; they acknowledged the doubt and did something anyway. A *responsive* person operates within a ‘complex context’ where a solution is available but not immediately obvious. A person must first ‘probe’ for a pattern, sense it, and then respond (Snowden & Boone, 2007). Room (2016) describes ‘probing’ as finding ways to cross knowledge gaps for new understanding. For example, a practice nurse at First Medical Care, said ‘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.’

Those that were *responsive* may be understood as ‘agile actors’ (Room, 2016). Agile actors are able to explore uncertain and complex environments from the comfort of stable knowledge and practices (Room, 2016). In the face of uncertainty, an agile actor can utilise heuristics (such as thresholds, alignment and sequences) to probe the environment and develop new mental models of how things may unfold. When exploring a complex environment, the use of a heuristic may trigger a

need to move from known knowledge into the unknown. An agile actor can then develop new mental models which manipulate or disrupt relationships to generate new opportunities.

Those who engaged with uncertainty experienced less doubt. For example, when a threshold was crossed requiring action, they asked questions to decrease doubt of what to do. A practice nurse at First Medical Care, held an ‘instinct that something’s not quite right’ which, when triggered, motivated her to ask more questions. Those that engaged with uncertainty did so with an understanding that their actions might trigger new opportunities for change.

[...] 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 [...] 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”, you know “come over here” whether it be five minutes, ten minutes, or just a breather for them just 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.
[Nurse, Whānau Oranga]

In contrast, avoiding uncertainty blocks *responsiveness*. For example, a GP at First Medical Care, did not ask about IPV for fear of a positive disclosure and the possibility of an extended consult.

Not knowing how things may unfold can also lead to surprise. Surprise is an unexpected occurrence, due to the unpredictability of complex adaptive systems. It is a novel combination of people and their reactions. Often, we see surprise as unfavourable, a threat, or failure, and we implement methods to avoid it from occurring again (e.g. quality improvement). Some people may normalise or deny surprise, or even enact surprise away so they know what to do and aren’t confused by new information (R. R. McDaniel & Driebe, 2010). In contrast, an agile actor would use surprise as an opportunity to reflect on their *response* and explore new ways of engaging with the complexity (R. R. McDaniel & Driebe, 2010; Room, 2016).

Although uncertainty generates doubt, they are not the same. Doubt should be understood as a lack of ‘effective’ responsiveness e.g. not knowing what to do because of an absence of support.

Uncertainty is an inherent part of *responsiveness*. Knowing what to do does not eliminate the uncertainty of what may unfold. We found ways uncertainty can be harnessed to improve responses to IPV. Instead of providing protocols prescribing how to respond effectively, we could provide resources that support and improve the effectiveness of our *responsiveness*. For example, a GP at

Family Care Practice, wanted processes in place to offset the feeling of isolation. A nurse practitioner at Whānau Oranga, wanted a better connection with community services. Responses to uncertainty will always be uncertain. Engaging with uncertainty makes more sense than struggling against it by minimising or ignoring it (Khan et al., 2018). As the practice manager of First Medical Care said:

Somebody that is being abused is probably as close to being truly in need as 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".

6.13 Limitations

Use of complexity theory means interaction with some system elements will innately remain obscured. The largest limitation of this study was the absence of care-seeker, community and whānau voices. Further research is needed to explore how the complex worlds of the care-seeker may influence health professional responses. Further, hearing the voices of Māori primary care professionals could have been improved by altering recruitment criteria to oversample Māori individuals, not kaupapa Māori general practices. Finally, the interview focused on IPV as a health issue, not a key determinant of ill-health. This would likely have shaped participant responses differently.

6.14 Conclusions

IPV is more than just a health issue, it is a key determinant of ill-health. Treating symptoms without addressing the cause is inadequate, ineffective, and unsafe. The relationship between IPV and ill-health is not well recognised, or understood in NZ, at both policy and practice levels. Our Triple R Pathway emerged from exploring health professional discourses on IPV as a health issue and provided the means to understand what affects sustainable responses to IPV within NZ primary care settings. We found inadequate recognition of socio-ecological determinants leads to a simple health system response to IPV constraining primary care professional *responsiveness*. To improve *responsiveness* to IPV, the health system must widen its approach by adequately engaging with socio-ecological contexts to recognise IPV as a key determinant of ill-health. This will shift the way we conceptualise a *response*, calling attention to new and different ways to be *responsive*.

We hypothesised sustainable responses to IPV will emerge when these patterns of interaction repeat to form a positive feedback loop at each level. As we are yet to witness sustainable responses, we were unable to prove this hypothesis. However, we called attention to many locally occurring interactions blocking the self-organisation of *responsiveness* to IPV. Most importantly, we must become comfortable in engaging with uncertainty, at both policy and practice levels. A considerable body of knowledge already exists which we may call on to help probe into the unknown, including listening to the expertise of the frontline. The absence of primary care within a multisectoral response continues to be a profound system gap that must be addressed if we are to prevent IPV in a sustainable way.

6.15 Insights from bringing data sources together

The preceding manuscript presented findings from my interviews with health professionals. In the following section I discuss two additional system blockages which are informed by both complete interview and document data sets. First, how a top down system focus works to limit response sustainability and second, the organisational isolation of general practice. I summarise the chapter at the end of this section.

6.15.1 *The limits of a top down approach*

To become *responsive*, we must consider *how* we approach responses to IPV within health care and other sectors so, as Moana (Primary Health Organisation Manager) of Whānau Oranga said, ‘there is always a solution which is mana enhancing for all, that safety and integrity are maintained, and choices are available.’ The *respond* stance is a critical link to being aware of ‘IPV as a health issue’ and how a *response* may be conceptualised. Implementing a prescribed *response* from the top down is problematic for sustainability as policy cannot shift individual and organisational *respond* stances, meaning deeply rooted stereotypes and racist discourses will be overlooked.

To date five different approaches to health system response implementation can be distinguished. In the beginning, the 1998 family violence guidelines were designed to support development of local health provider responses, then the events which took place around the death of James Whakaruru in 1999 shifted the responsibility of implementation to District Health Boards. In 2002, the Ministry of Health guidelines were designed to be applicable and adaptable to diverse health professions and settings and in 2016 recommended a whole of system approach to family violence intervention and assessment. Most recently, the government family violence frameworks seek to establish a common and consistent approach across all agencies, services and practitioners.

Each of the approaches were ‘top down’ and each failed to engage the primary care sector (Gear et al., 2018b). We argue top down implementation approaches articulate an ideal but have limited influence shifting system relationships or structure and ultimately responsiveness. For example, addressing ‘interpersonal violence’ was a priority in the NZ Health Strategy 2000, yet marked improvement in primary care responsiveness did not become apparent (Gear et al., 2018b;

Ministry of Health Manatū Hauora, 2000, p. 13). Context adds to the complexity of the problem, challenging the feasibility of standardised approaches to implementation (Braithwaite, Churruca, Long, Ellis, & Herkes, 2018). The current focus on top down directives coupled with an absent IPV policy directive, obscures IPV as a key determinant of ill-health across the health system.

We found participants who recognised the relationship between IPV and socio-ecological determinants struggled to practice differently within a restrictive health system. Te Whānau Hauora represented an exception. They rejected the public health approach, were cognisant of socio-ecological determinants and matched their *response* to the complexity. Their *respond* stance, ‘we engage differently with whānau’ and *response* discourse ‘because it doesn’t happen like that’ generated an adaptability which gave the practice resilience to the changing environment. Their *respond* stance left room to co-evolve alongside whānau, generating a self-organising *responsiveness*. For example, Hana, the practice manager, describes intervening in the ‘underlying issues’ of IPV and ‘picking up the pieces’, whatever those might be. However, the Te Whānau Hauora *response* only intervenes after violence occurs. *Responsiveness* could be improved by the health system adequately funding and recognising alternate *responses*.

The Primary Care Working Group on General Practice Sustainability (2015) found a widespread perception that the current funding structure for primary care was not ‘fit for purpose’ (p. 19). I found the structure and funding of primary care contributed to the negative feedback loop that undermines and undervalues the voices of the frontline. For example, Moana, the Primary Health Organisation Manager of Whānau Oranga, cited the struggle of ‘being true to our vision and contract compliant’ as a key barrier in delivering effective services. The top down approach means general practices are focused on remaining Ministry of Health contract compliant to receive funding and stay viable as a business. Sally, practice manager at Family Care Practice, described their Primary Health Organisation as their ‘bread and butter’.

For kaupapa Māori general practices in particular, addressing complex health and social problems necessitates different ways of working. My findings clearly show Māori are striving to deliver a model of care more effective for their people. The key policy document E Tu Whānau articulates that Māori can successfully address violence within whānau utilising Māori strengths,

formally opening space for Māori to lead the design and implementation of their own solutions (Māori Reference Group for the Taskforce for Action on Violence within Families, 2013). Yet my findings illustrated the significant challenges involved in transforming services and care to a kaupapa Māori philosophy within a health system focused on the general population. I found no relationship between E Tu Whānau and primary care in either document or interview data, a clear system gap, though not surprising considering the lack of attention to family violence in the primary care sector. Supporting responsiveness within kaupapa Māori general practices necessitates Māori mana motuhake (self-determination).

A top down focus obscures contextual factors critical to implementation, favouring an ideal outcome i.e. standardised best practice, over actual structural influence i.e. uptake. This is illustrated in the ‘real world’ struggles of general practices to transform services and practices to effectively address complex health and social problems. Policies, such as E Tu Whānau, assume the desired outcome is possible e.g. Māori mana motuhake, without consideration for structural barriers, e.g. poor recognition of socio-ecological determinants of violence. The next section discusses an additional hurdle of general practice isolation.

6.15.2 General practice isolation

Nationally, relationships between primary care, hospital and community services are highly variable (Primary Care Working Group on General Practice Sustainability, 2015). During the study I sensed general practice was organisationally isolated from other health and social services. For example, the practice manager of Whānau Oranga spoke of the impact a poor connection with community services had on service quality and questioned whether general practice(s) were aware of services available to them. She also described her struggle to provide ongoing general training for her staff, being unable to host their own training and blocked from attending training hosted by others. Individual health professionals also felt isolated in their practice. The GPs from Family Care Practice and Whānau Oranga both voiced concerns about feeling alone or isolated from peer support when dealing with sensitive issues such as IPV or mental health. For IPV specifically, there was a common lack of

knowledge of appropriate referral agencies, and how to refer to them, which increased doubt of what to do.

Braithwaite (2010) argues solutions can be found in studying these gaps, not the groups or networks it involves. Exploring the spaces, holes or missing ties between groups can call attention to system weaknesses, where bridge building is needed, and where and what to focus our attention on for improvement. For example, despite intimate partner violence often involving sexual violence there are often gaps between them in education and service delivery. The nurse practitioner at Family Care Practice was responsive to a historical sexual assault disclosure without workplace support (such as protocols), yet she was unsure how she would access IPV information and resources for a patient. The government workforce capability framework aims to strengthen the system by bridging these gaps through a common understanding of, and consistent approach to, responding to family violence and sexual violence (Ministry of Social Development, 2017).

Studying the gaps involved in the organisational isolation of general practice can help to improve integration of health and social services. Future research should explore the gap between the Ministry of Health and the primary care sector regarding family violence to understand where system weaknesses and missing ties lie. Addressing this gap may also impact on other sensitive health issues, reducing the isolation GPs experience.

6.16 Chapter Summary

Reducing the impact of the health effects of violence is not enough. To address the cause, the health system must recognise the role wider system elements play in both the experience of violence and in how we respond to it as health care professionals. In this chapter, I introduced the Triple R Pathway as a complex adaptive system approach useful for mapping influences on sustainability. I called attention to what influences how we think about an IPV response in primary care and how that shapes our responsiveness to someone experiencing violence. Use of the Triple R Pathway, showed how an inadequate relationship between the health system and socio-ecological determinants of violence, leads to a simple health system response to family violence which constrains primary care professional responsiveness.

In the final section of this chapter, I brought together both document and interview data sources to illustrate the relationship between health system context and health care practice. I showed how complexity theory can enhance implementation science by calling attention to the influence of contextual elements on sustainability. My findings called attention to how a top down implementation approach and the organisational isolation of general practice challenges the emergence of sustainable responses to IPV. The next chapter concludes the thesis. I summarise my main findings and implications for policy and practice.

Chapter 7 Becoming Responsive

The New Zealand (NZ) health system has been slow to respond to the epidemic of violence within families and whānau. More distressing is the continued under-utilisation of the primary care sector in identifying and responding to family violence. However, simply implementing an effective intervention to address this ‘complex problem’ is not enough. My own experiences utilising traditional quality improvement methods to support primary care responsiveness signalled the need for a different perspective and approach. I undertook this research to contribute to the international gap in knowledge on how IPV interventions may become sustainable across health care settings, asking ‘What affects a sustainable response to IPV within NZ primary care settings?’ My thesis contributes complexity theory as a new qualitative research methodology which can challenge existing ways of thinking and expose knowledge obscured by other theoretical perspectives.

I found the principal influence on sustainable health care responses to IPV is the absent recognition of IPV as a key determinant of ill-health. This lack of recognition allows the health system to simply respond to the health effects of violence, without understanding, or addressing, the causes. The implications of this spans health system levels. This chapter synthesises the key contributions my thesis makes to the fields of IPV, complexity theory and sustainability. I discuss the practical implications for the health system and indicate future research opportunities. In the first section I discuss the implications of the findings for improving IPV responsiveness, in the second section reflect on my use of complexity theory and in the third section synthesise what I learnt about the sustainability. Finally, I synthesise study limitations discussed throughout the thesis and make my concluding remarks.

7.1 Moving forward: IPV as a key determinant of ill-health

A key contribution my thesis makes is extending the notion of IPV as a health issue, to IPV as a key determinant of ill-health. I am thankful to my study advisor Dr Clare Healy for helping me realise this distinction. In chapter four, my implementation narrative called attention to reasons why primary care is currently under-utilised in reducing family violence. I found for the health system to become more

responsive, IPV must be recognised as a key determinant of ill-health. This means explicitly committing to addressing violence as a key determinant of ill-health and adequately reflecting this within health strategies and policy directives. Doing so would ease the way for needed interactions between the Ministry of Health, primary care and the Violence Intervention Programme to take place, leading to improved primary care engagement and participation in the health system response to family violence.

In chapter six, I found an inadequate understanding of the relationship between primary care and socio-ecological contexts prevented an understanding of IPV as a key determinant of ill-health. The fact that health professionals, often unknowingly, treat the effects of IPV without addressing the cause is known. I argue the lack of connection with socio-ecological contexts enables this by obscuring the determinants which contribute to violence within families, challenging the emergence of a sustainable response. There is scope for future research to explore this insight more deeply.

In referring to IPV as a key determinant of ill-health I deliberately use the word ‘recognise’, which does not mean prescribing a response. In chapter six, the Triple R Pathway, emergent from interview data analysis, clearly shows prescribing a response is not a sustainable solution as any response will be rearticulated by an individual or organisation based on who they are and how they understand the problem. Instead, health professionals should be supported by numerous response options that they may draw on as individuals and organisations. Chapter four introduces the new government family violence frameworks that seek to establish a common understanding and consistent approach to family violence by setting a national evidence-based best practice standard for government agencies to work towards (Ministry of Justice, 2017; Ministry of Social Development, 2017). I argue the frameworks signify the most prominent sign of progress on the family violence pathway. However, it also marks a return to the original implementation plan. Like the 1998 family violence guidelines, the frameworks function to signal a consistency while making organisations responsible for their development and use. They function to provide a definition of what a response looks like. My findings indicate access to best evidence is useful, but how evidence is applied in practice will always be variable. How we use best practice information must be critically reflected on.

One way to begin working towards responsiveness could be to support a general practice to meet and discuss their individual respond stances, address stereotypes and consider the latest research and evidence, such as the government frameworks. The general practice can generate an agreed on respond stance from which a response, responsiveness and sustainability may follow. Critically, a general practice respond stance must also include the voices and diversity of the patient population. Supporting strong general practice respond stances will lead to a response tailored to the general practice values and needs and support the self-organisation of responsiveness. This approach to implementation allows general practices to consider their own context and match a response.

Practicing Trauma- and Violence-Informed Care (TVIC) is another way to influence the respond stance. TVIC is grounded in the recognition that violence and trauma are social determinants of health (Varcoe, Wathen, Ford-Gilboe, Smye, & Browne, 2016). It recognises how systemic, interpersonal violence and structural inequities intersect to impact on health (Marmot, 2015). For example, racist health policies and practices can amplify initial trauma when seeking care. To improve health, the social and economic inequalities that shape a life course must be recognised (Marmot, 2015). The TVIC approach assumes the presence of trauma, moving away from a goal of disclosure to providing safe and effective care for everyone (Varcoe et al., 2016).

In summary, the absent recognition of IPV as a key determinant of ill-health is the principal influence blocking sustainable responses to IPV across health system levels. This finding has significant implications for moving the health system response to family violence forward. Rather than imposing prescribed responses, recognising IPV as a key determinant of ill-health shifts towards providing resources which may support and improve current practice across health settings and disciplines. This should be supported by identifying and disrupting system interactions that block the full potential of health professional responsiveness to IPV.

7.2 Insights from complexity theory

In chapter two, I developed a framework conceptualising sustainable responses to IPV as complex adaptive systems. This process reconfigured the problem frame, recognising the influence of many different contexts. Often other research approaches obscure these contexts which contribute to the

problems researchers face in developing and implementing effective and sustainable IPV interventions. In this thesis I call attention to the respond stance as a commonly obscured context. Often, we focus on what the response is and how it is carried out. In chapter six, the Triple R Pathway shows how a health professional or organisation respond stance influences how we think about a response. Effective responses rely on the realisation of the inherent connection between the respond stance and IPV as a key determinant of ill-health. To support the emergence of sustainable responses to IPV, the context of the respond stance must be considered.

Another key contribution of this thesis, to both the intimate partner violence and complexity theory fields, is my explication of complexity theory as a qualitative research methodology. In chapter three, I present a complexity theory methodological approach considering the choices of theoretical approach, research question, and data collection methods. The chapter provides an indication of what data analysis might look like, later explicated in chapters four and six. Publishing this work advances both complexity theory application and qualitative research design. The manuscript was accessed a significant number of times in the first six months of publication.

This thesis presents insight into why IPV interventions are difficult to implement and sustain. Use of complexity theory improves implementation science by calling attention to contextual factors and patterns of interaction influencing the implementation pathway (Braithwaite et al., 2018). My findings in chapters four and six indicate a large gap between practice ('bottom') and policy ('top') levels. Informed by complexity theory, I hypothesise a sustainable IPV response as emergent from the interaction between the care-seeker and health professional. A response designed with limited engagement with frontline professionals overlooks the importance of the interaction between the health professional and care-seeker - the interaction that initiates future patterns of interaction leading to a sustainable response. To support sustainability, policy must reflect an understanding of this interaction, which requires closer engagement with the frontline.

In the last section of chapter six, where I bring my data sources together, I argue top down implementation approaches articulate an ideal but have limited influence shifting system relationships or structure. This was evident in chapter four, in the general practitioner (GP) dissent of the 2002 family violence intervention guidelines. From a complexity perspective, policy and management

should facilitate system interactions that support the self-organisation of health professional and general practice responsiveness. This ‘bottom up’ approach is more likely to lead to the emergence of system structures supporting sustainable responses to IPV. It also allows for intervention adaptability. As Snowden and Boone (2007) said, ‘Leaders who try to impose order in a complex context will fail, but those who set the stage, step back a bit, allow patterns to emerge, and determine which ones are desirable will succeed’ (p. 74). The top down approach undermines and undervalues the voices of the frontline contributing to the misalignment between the simple context of the current health system response and the chaotic context of responding to IPV in primary care. Future research could explore this perceived misalignment.

This thesis developed and designed a methodological approach useful in exploring complex problems. This approach calls attention to contexts often obscured by other research methodologies. It proposes new ways to work which better support the emergence of sustainability. By explicating the process, this thesis makes this approach accessible to others exploring complex problems.

7.3 The notion of sustainability

In chapter two, I presented a complexity-informed conceptualisation of sustainability, as an evolving and adaptive process generated by the interaction between agents. I hypothesised sustainability would emerge when patterns of interaction between the care-seeker and health professional generated mutually beneficial outcomes. This conceptualisation led to three key insights that challenge existing knowledge on IPV intervention sustainability.

First, my view of the health system as a series of complex adaptive systems challenges the validity of an intervention ‘pipeline’ approach, assuming a linear pathway from design to impact (Braithwaite et al., 2018). Instead, this study shows an intervention can be a very small change that generates new interactions within the complex adaptive system. The intervention may not always generate the desired effect, but when it does, possibilities are amplified. Complex adaptive systems can be understood as a product of both intentional and emergent interactions. Intentional intervention, such as imposed policy, within a complex adaptive system introduces human reflexivity, whereby perception and actions generate new dynamics Khan et al. (2018). I argue the health system may be

intentionally intervened in to promote self-organisation and emergence. For example, studies have shown how just asking about IPV initiates new interactions. Koziol-McLain et al. (2008) found asking about IPV could contribute to transforming communities, as women who were screened for IPV went back to their families, friends and communities and passed along resource information. Spangaro et al. (2011) found resource information was used by women with their abuser as an indirect or direct way to name their behaviour. These studies evidence the wide range of potential outcomes a small change can generate. Braithwaite et al. (2018) argues the 'pipeline' approach was outdated a decade ago, yet some still persistently hold that view. It seems the intimate partner violence field is still in transition with Varcoe et al. (2016) recently noting interventions are shifting from an individual approach to understanding violence as 'a persuasive social problem embedded in social and structural inequities' (p. 4). This thesis argues large scale IPV interventions are unwarranted, rather small changes can be made which lead to big effects.

Second, in chapter six, I noted current thinking views intervention variability as problematic for sustainability (Colombini et al., 2017; Goicolea et al., 2013; O'Campo et al., 2011). My findings directly contradict this. Instead, I found engaging with the uncertainty of the complex adaptive systems leads to the emergence of new opportunities for change and improvement. Health professionals who engaged with uncertainty experienced less doubt of how to respond to IPV. This thesis makes a novel contribution by distinguishing between doubt and uncertainty. Doubt is generated by a lack of system support, whereas knowing what to do does not eliminate the uncertainty of what may unfold. This study shows the existence of doubt directly impacts how responsive health professionals are to IPV. Leaving health professionals ill-equipped to respond to IPV is a serious failure of the health system. On the other hand, trying to remove doubt through a prescriptive response, is likely to compound doubt by obscuring relevant context, further compounding uncertainty.

Third, as I wrote in chapter six, despite the lack of system support for the primary care sector, I found some health professionals were still responsive to those experiencing family violence. This challenges the idea that formal systems, such as a policy directive, need to be in place before responsiveness can occur. Obviously, the effectiveness of responsiveness will be greater with system

support. Moreover, I found there are multiple ways health professionals could be responsive to someone experiencing IPV. This challenges the health system to be more inclusive of alternative ways to be responsive.

In summary, interventions are often designed to achieve certain outcomes, obscuring other contexts and narrowing how sustainability is understood. Along with others, I argue sustainability continually emerges from interactions within a complex adaptive systems, widening the scope to include many diverse contexts (Hawe, 2015; Shani & Mohrman, 2012). This thesis shows when sustainability is understood as emergent phenomenon, the value of making multiple small, rather than large, interventions in the system becomes more conceivable. Uncertainty becomes something not feared but useful and multiple methods of responsiveness become evident. A sustainable response to IPV remains elusive because it is emergent. A sustainable response to IPV is not something that can be achieved in perpetuity, but something we must work towards, constantly making adjustments to promote the desired outcome.

7.4 Limitations

This section synthesises study limitations discussed throughout the thesis. My use of complexity theory as a qualitative research methodology was innovative within the field and there was a scarcity of literature for guidance. I learnt that any representation of complexity is always partial, static and subjective to the context they are discussed within. Further, the continuously evolving nature of complex adaptive systems means witnessing the same event twice is highly unlikely. I maintained rigor through continuous responsiveness to methodological congruence. For example, rather than applying a Foucauldian discourse analysis, I found literature which helped me conceptualise discourse as a complex adaptive system. As an agent within the complex adaptive system being studied, researcher influence naturally occurs, aligning with my post-structural perspective underpinning the study. More traditional research paradigms preferring objectivity may view researcher influence as a limitation. To promote rigor, I called attention to interactions I explicitly influenced throughout the thesis to be transparent to the reader. For example, how the research interview acted as an unintentional intervention, requiring participants to reflect on their own practice.

A complexity research design innately obscures system elements depending on the perspective, methods and boundaries chosen. The clearest example of this in my study was the absence of care-seeker, community and whānau voices. Hearing the voices of Māori primary care professionals could have been improved by altering recruitment criteria to oversample Māori individuals, not kaupapa Māori general practices. Future research should explore how the complex worlds of the care-seeker may influence health professional responses.

I had intended data collection and analysis to be concurrent to allow for reflection and learning between interviews. While interviews were conducted during the document analysis phase, to keep the momentum and interest of health professionals, interviews often took priority over document analysis. This would have shaped data collection, such as influencing my choice of interview questions. I found complexity-led interviewing widely differed to interviewing within other research methodologies, being more conversational than a question and answer style. To elicit diversity and complexity, I had to be able to probe into what was influencing participant thinking in real time without leading responses. I would be interested in learning from others' experiences of conducting complexity-led interviewing to improve this skill.

A complexity researcher must resist the tendency toward reductionism, yet research design naturally places boundaries around the complex adaptive system being studied. In this study, recruitment of four general practices in one region limited some diversity of primary care settings. However, the choice of sample size was not intended to make generalisations but to study current action within local settings. A large sample size was not needed to evidence current practice ineffectiveness. Document analysis was limited by a focus on documents that directly influenced IPV responsiveness in health care, omitting wider influences such as community responsiveness or gender equality. For example, NZ reports from the United Nations Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) were excluded for the lack of focus on health. I did find narrative analysis of interview data effective in preserving diversity and complexity.

Reflecting on these limitations, use of complexity theory as a methodology must make visible the research design choices made and why. From a complexity perspective, limitations do not 'limit' study findings, rather map the boundaries in which the study was conducted for future research to

consider. Complexity research that fails to be transparent regarding research design does limit understanding. Future research should clearly articulate how and why complexity theory is used to advance use of complexity theory as a qualitative research methodology.

7.5 Concluding remarks

The high rates of family violence in NZ are well known but the impact on health and wellbeing is not. Given the multisectoral efforts to reduce violence, the under-utilisation of the primary care sector is a profound system gap. Understanding the difficulty in implementing and sustaining health care responses to IPV, I sought to find out what affects a sustainable response to IPV within NZ primary care settings. Utilising complexity theory, I explored the context and implications of an inadequate primary care response to IPV.

I identified three major system interactions blocking the self-organisation of responsiveness to IPV within primary care. First is the absence of recognising IPV as a key determinant of ill-health within policy and practice. Without this recognition, the response becomes tenuous across clinician, general practice and system levels and the health system will continue to generate inadequate responses to IPV. The second is the manifestation of doubt primary care professionals experience. To become fully, and safely, responsive health professionals must be supported by response options adaptable to the uncertainty of what might unfold. Prescribing what a response looks like is less likely to lead to improved responsiveness as it is incongruous with the uncertain context the interaction between care-seeker and health professional takes place within. This misalignment between the health system response and the complexity of the problem needs to be addressed. The third is the focus on top down implementation approaches which fail to account for context and diversity. The current model of care has significant implications for Māori in both providing and receiving inequitable and ineffective care. The organisational isolation of general practice is an additional hurdle for providing services responsive to increasingly complex health needs. How we approach implementation must be reconsidered to improve uptake and spread in the primary care sector.

This thesis is distinctive in its use of complexity theory as a qualitative research methodology. Complexity theory depicts sustainable family violence responses as having an emergent nature. Promoting the emergence of sustainability involves being open to different ways of being responsive and what outcomes are considered useful. Future research must be inclusive of this diversity. The complexity of the problem means it is difficult to determine a ‘beginning’ and ‘end’ of family violence and the impact on health. Similarly, there is no end-point of a sustainable response to family violence, it must be continually worked towards.

No one should suffer a violent relationship. The overall implication of my thesis is that we can and should be thinking differently about how we may work to reduce violence. Primary care professionals are willing to address IPV, the next step is to assist the sector in being able to. My hope is that this research will spark new system interactions to work towards generating sustainable and effective responses to IPV.

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Appendix A Ethics approvals

1 March 2017
Jane Koziol-McLain
Faculty of Health and Environmental Sciences

Dear Jane

Re Ethics Application: **17/31 Sustainability of an intimate partner violence response within primary health care: A complexity analysis.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 1 March 2020.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 1 March 2020;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 1 March 2020 or on completion of the project.
-

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: cgear@aut.ac.nz

23 March 2017
Jane Koziol-McLain
Faculty of Health and Environmental Sciences

Dear Jane

Re: Ethics Application: **17/31 Sustainability of an intimate partner violence response within primary health care: A complexity analysis.**

Thank you for your request for approval of amendments to your ethics application.

I have approved minor amendments to your ethics application allowing xxx.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTECH):

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 1 March 2020;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 1 March 2020 or on completion of the project.
-

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: cgear@aut.ac.nz

4 September 2017
Jane Koziol-McLain
Faculty of Health and Environmental Sciences

Dear Jane

Re: Ethics Application: **17/31 Sustainability of an intimate partner violence response within primary health care: A complexity analysis.**

Thank you for your request for approval of an amendment to your ethics application. The amendment to modify the consent process is approved (additional bullet point for the PHO to agree not to disclose the identity of the practice) is approved.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>.
3. Any amendments to the project must be approved by AUTEK prior to being implemented. Amendments can be requested using the EA2 form: <http://www.aut.ac.nz/researchethics>.
4. Any serious or unexpected adverse events must be reported to AUTEK Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEK Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project. AUTEK grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,



Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee
Cc: cgear@aut.ac.nz

Appendix B Final participant information sheets and consent forms

7.6 General Practice Information Sheet

What affects a sustainable response to intimate partner violence in primary health care?

Thank you for showing an interest in this research. Please read this information sheet carefully before deciding to grant permission for GENERAL PRACTICE to participate. If GENERAL PRACTICE decides to participate, thank you. If not, there will be no disadvantage to you, or your practice.

Introduction

I would like to invite you to participate in PhD research which seeks to support effective primary health care responses to victims of intimate partner violence. More than one in three New Zealand women experience intimate partner violence during their lifetime, causing significant adverse health effects and higher health care service use. The primary health care setting may be a victim's first or only point of contact with a health professional who can facilitate access to care and support across health care services, as well as access to the multi-sectoral response. While women identify health professionals as someone they would trust to seek help from, doctors and nurses continue to feel a lack of confidence and support to ask women about IPV. Further, there is currently no national strategy informing a comprehensive response to IPV within New Zealand primary health care, allowing for extreme variation and potentially harmful responses to victims.

Objective of the research

I am seeking to understand what affects sustainable responses to intimate partner violence within New Zealand primary health care settings. Internationally, implementing a health system response to IPV has proven challenging, and the best approach is still unknown. Using an innovative theoretical perspective, my research will identify what interactions between the health care system and general practice influence sustainable responses to victims of intimate partner violence. This will highlight opportunities for influencing change within the health care system to inform better approaches to keeping New Zealanders safe from violence.

About this research

My PhD study builds on previous work conducted by the Interdisciplinary Trauma Research Centre at AUT University (see below references). Literature shows what components are needed to support effective responses to IPV in health care settings, but further research is needed to understand how complex health care system relationships can be utilised to support the sustainability of responses within primary health care. My PhD seeks to understand how interactions between the health care system and general practice influence and shape each other. To do this I will concurrently analyse documents which guide primary health care service delivery with regard to IPV responsiveness and interview key primary health care professionals from different general practices.

What will participants be asked to do?

I would like to invite GENERAL PRACTICE to participate in this research as one of four participants. Participation involves thirty-minute individual interviews with the general practice manager, a general practitioner, a practice nurse and any other relevant people (such as a social worker or receptionist) about responding to intimate partner violence as a health issue.

I would also be interested in observing (as a non-participant) and recording general practice meetings which discuss the implementation of a new health programme if they occur during your participation in this study. Should you decline this, you may still participate in the study.

To further understand the health system context for GENERAL PRACTICE, I am also seeking to interview the Primary Health Organisation manager associated with your general practice.

Please note GENERAL PRACTICE does not have to be currently addressing IPV as a health issue to participate in the study. I am seeking to talk with different general practices to understand how a sustainable response to intimate partner violence might be achieved. As such, there can be no right or wrong opinions. Those who are interviewed may like to accept a \$50 supermarket voucher to compensate for any costs incurred (such as loss of patient consultation time) by participating in this research.

What data or information will be collected?

All information gathered from GENERAL PRACTICE will be treated as confidential. No identifying personal or organisational information will be used in any publication of the data. However, it is likely individual participants within the same organisation will be aware of others participation in the study. Interviews will be recorded and transcribed by myself as the primary researcher. All information will be accessible only to myself and study advisors (see details below) and will be securely stored. At the end of the study personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for ten years, after which it will be destroyed.

What are the benefits?

Your contribution to this research will help to inform effective, sustainable health care responses to New Zealanders who are experiencing violence. Research findings will fill a gap in international literature on how to best respond to intimate partner violence within primary health care and contribute to supporting the work of voluntary primary health care professionals who are actively responding to intimate partner violence in New Zealand.

The findings of my PhD study will be widely disseminated within Māori and primary health care communities as well as within academic health care journals and at national and international conferences. GENERAL PRACTICE will receive copies of publications and an invitation to the study findings presentation.

Confidentiality and Care

This research seeks to understand how the health care system can support effective, sustainable responses to IPV. I will not ask individuals about intimate partner violence experiences, patient or personal. I also recognise the competitive primary health care environment for resourcing initiatives which may or may not be Ministry of Health directed. This study does not ask GENERAL PRACTICE to initiate a response to intimate partner violence.

All information gathered from GENERAL PRACTICE will be treated as confidential. Participation in this research is voluntary and whether or not you choose to participate will neither advantage nor disadvantage your practice. Each staff member who participates in the study will be asked for their informed consent prior to being interviewed. Interviewees may also request to review their transcript.

GENERAL PRACTICE is able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to your practice removed or allowing it to continue to be used. However, once the findings have been produced, removal of data may not be possible.

Information on preventing and intervening in family violence is available on the It's Not OK website (www.areyouok.org.nz). It's Not OK also provides a free helpline (0800 456 450) which can connect you to services that can help if you are experiencing or witnessing violence – or if you want to change your own behaviour. It is OK to ask for help.

How do I agree to participate in this research?

If GENERAL PRACTICE agrees to participate in this research, please sign the attached consent form and return by email to the primary researcher Claire Gear - cgear@aut.ac.nz.

If you have any questions:

Please feel free to contact myself or my supervisors if you have any questions about the research, now or in the future. I am happy to meet with you to discuss the study further.

Claire Gear, Doctoral Candidate
Interdisciplinary Trauma Research Centre, AUT University
Phone: 0273574845 Email: cgear@aut.ac.nz

Study Advisors:

Academic Supervisors:

Professor Jane Koziol-McLain
Centre for Interdisciplinary Trauma Research
AUT University
Email: jkoziolm@aut.ac.nz
Phone: (09) 921 9670

Dr Elizabeth Eppel
School of Government
Victoria University of Wellington
Email: elizabeth.eppel@vuw.ac.nz
Phone: (04) 463 7425

Primary Health Care Consultants:

Anna Rolleston, Director, Cardiac Clinic
Tauranga
Clare Healy, HaswellHealth, Christchurch

Cultural Consultant:

Tamati Tata, Huria Marae Tauranga

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Jane Koziol-McLain, jane.koziol-mclain@aut.ac.nz, (09) 921 9670.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Previous Research

Gear, C., Koziol-McLain, J., Wilson, D., & Clark, F. (2016). Developing a response to family violence in primary health care: The New Zealand experience. *BMC Family Practice*, 17, 115. doi:10.1186/s12875-016-0508-x

Gear, C., Koziol-McLain, J., Wilson, D., Rae, N., Samuel, H., Clark, F., & McNeill, E. (2012). Primary healthcare response to family violence: A Delphi evaluation tool. *Quality in Primary Care*, 20(1), 15-30.

***Approved by the Auckland University of Technology Ethics Committee on 1 March 2017
AUTEK Reference number 17/31***

7.7 General Practice Permission to Access Staff and Records Form

What affects a sustainable response to intimate partner violence in primary health care?

Name of General Practice: _____

Name of General Practice Manager: _____

I have read the Information Sheet concerning this research and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any time.

- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (choice of GENERAL PRACTICE) and that GENERAL PRACTICE may withdraw from the study at any time without being disadvantaged in any way.
- I give permission to access and use GENERAL PRACTICE documents for the purposes of this research (such as meeting minutes, documentation forms or policies).
- I give permission for the researcher to attend and record general practice meetings which discuss the implementation of a new health innovation for the purposes of this research.
- I understand that no identifying information will be used in any publication of the research.
- I understand that if GENERAL PRACTICE withdraws from the study then I will be offered the choice between having any data that is identifiable as belonging to GENERAL PRACTICE removed or allowing it to continue to be used. However, once the findings have been produced, removal of data may not be possible.
- I give permission for GENERAL PRACTICE to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Authorising

signature:

Phone: _____

Name:

Email: _____

Date: _____

**Approved by the Auckland University of Technology Ethics Committee on 1 March 2017
AUTEC Reference number 17/31**

Note: The Participant should retain a copy of this form.

7.8 Individual Information Sheet

What affects a sustainable response to intimate partner violence in primary health care?

Thank you for showing an interest in this research. Please read this information sheet carefully before deciding to participate. If you decide to participate, thank you. If not, there will be no disadvantage to you, or your practice.

Introduction

I would like to invite you to participate in PhD research which seeks to support effective primary health care responses to victims of intimate partner violence. More than one in three New Zealand women experience intimate partner violence during their lifetime, causing significant adverse health effects and higher health care service use. The primary health care setting may be a victim's first or only point of contact with a health professional who can facilitate access to care and support across health care services, as well as access to the multi-sectoral response. While women identify health professionals as someone they would trust to seek help from, doctors and nurses continue to feel a lack of confidence and support to ask women about IPV. Further, there is currently no national strategy informing a comprehensive response to IPV within New Zealand primary health care, allowing for extreme variation and potentially harmful responses to victims.

Objective of the research

I am seeking to understand what affects sustainable responses to intimate partner violence within New Zealand primary health care settings. Internationally, implementing a health system response to IPV has proven challenging, and the best approach is still unknown. Using an innovative theoretical perspective, my research will identify what interactions between the health care system and general practice influence sustainable responses to victims of intimate partner violence. This will highlight opportunities for influencing change within the health care system to inform better approaches to keeping New Zealanders safe from violence.

About this research

My PhD study builds on previous work conducted by the Interdisciplinary Trauma Research Centre at AUT University (see below references). Literature shows what components are needed to support effective responses to IPV in health care settings, but further research is needed to understand how complex health care system relationships can be utilised to support the sustainability of responses within primary health care. My PhD seeks to understand how interactions between the health care system and general practice influence and shape each other. To do this I will concurrently analyse documents which guide primary health care service delivery with regard to IPV responsiveness and interview key primary health care professionals from different general practices.

What will participants be asked to do?

I would like to talk with you for 30 minutes about responding to intimate partner violence as a health issue. Please note GENERAL PRACTICE does not have to be currently addressing IPV as a health issue for you to participate in the study.

To further understand the health system context for GENERAL PRACTICE, I am also seeking to interview the Primary Health Organisation manager associated with your general practice.

I am seeking to talk with different general practices to understand how a sustainable response to intimate partner violence might be achieved. As such, there can be no right or wrong opinions. You may like to accept a \$50 supermarket voucher to compensate for any costs incurred (such as loss of patient consultation time) by participating in this research.

What data or information will be collected?

Your interview will be recorded and transcribed by me. No identifying personal or organisational information will be used in any publication of the data. All information will be kept confidential, accessible only to myself and study advisors. However, individual participants within the same organisation will likely be aware of others participation in the study. The data collected will be securely stored. At the end of the study personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for ten years, after which it will be destroyed.

What are the benefits?

Your contribution to this research will help to inform effective, sustainable health care responses to New Zealanders who are experiencing violence. Research findings will fill a gap in international literature on how to best respond to intimate partner violence within primary health care and contribute to supporting the work of voluntary primary health care professionals who are actively responding to intimate partner violence in New Zealand.

The findings of my PhD study will be widely disseminated within Māori and primary health care communities as well as within academic health care journals and at national and international conferences. GENERAL PRACTICE will receive copies of publications and an invitation to the study findings presentation.

Confidentiality and Care

This research seeks to understand how the health care system can support effective, sustainable responses to IPV. I will not ask you about intimate partner violence experiences, patient or personal. I also recognise the competitive primary health care environment for resourcing initiatives which may or may not be Ministry of Health directed. This study does not ask GENERAL PRACTICE to initiate a response to intimate partner violence.

All information gathered from GENERAL PRACTICE will be treated as confidential. You may request to review your interview transcript. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. Each staff member participating in the study will be asked for their informed consent prior to being interviewed.

You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Information on preventing and intervening in family violence is available on the It's Not OK website (www.areyouok.org.nz). It's Not OK also provides a free helpline (0800 456 450) which can connect you to services that can help if you are experiencing or witnessing violence – or if you want to change your own behaviour. It is OK to ask for help.

How do I agree to participate in this research?

If you agree to participate in this research, please email the primary researcher Claire Gear - cgear@aut.ac.nz to schedule a 30-minute interview at a time that suits you.

If you have any questions please contact:

Please feel free to contact me or my supervisors if you have any questions about the research, now or in the future. I am happy to meet with you to discuss the study further.

Claire Gear, Doctoral Candidate, Interdisciplinary Trauma Research Centre, AUT University, Phone: 0273574845 Email: cgear@aut.ac.nz

Study Advisors:

Academic Supervisors:

Professor Jane Koziol-McLain
Centre for Interdisciplinary Trauma Research
AUT University
Email: jkoziolm@aut.ac.nz
Phone: (09) 921 9670

Primary Health Care Consultants:

Anna Rolleston, Director, Cardiac Clinic
Tauranga
Clare Healy, HaswellHealth, Christchurch

Dr Elizabeth Eppel
School of Government
Victoria University of Wellington
Email: elizabeth.eppel@vuw.ac.nz
Phone: (04) 463 7425

Cultural Consultant:

Tamati Tata, Huria Marae Tauranga

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Jane Koziol-McLain, jane.koziol-mclain@aut.ac.nz, (09) 921 9670.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Previous Research

Gear, C., Koziol-McLain, J., Wilson, D., & Clark, F. (2016). Developing a response to family violence in primary health care: The New Zealand experience. *BMC Family Practice*, 17, 115. doi:10.1186/s12875-016-0508-x

Gear, C., Koziol-McLain, J., Wilson, D., Rae, N., Samuel, H., Clark, F., & McNeill, E. (2012). Primary healthcare response to family violence: A Delphi evaluation tool. *Quality in Primary Care*, 20(1), 15-30.

***Approved by the Auckland University of Technology Ethics Committee on 1 March 2017
AUTEK Reference number 17/31***

7.9 Primary Health Organisation Manager Information Sheet

What affects a sustainable response to intimate partner violence in primary health care?

Thank you for showing an interest in this research. Please read this information sheet carefully before deciding to participate. If you decide to participate, thank you. If not, there will be no disadvantage to you, or your practice.

Introduction

I would like to invite you to participate in PhD research which seeks to support effective primary health care responses to victims of intimate partner violence. More than one in three New Zealand women experience intimate partner violence during their lifetime, causing significant adverse health effects and higher health care service use. The primary health care setting may be a victim's first or only point of contact with a health professional who can facilitate access to care and support across health care services, as well as access to the multi-sectoral response. While women identify health professionals as someone they would trust to seek help from, doctors and nurses continue to feel a lack of confidence and support to ask women about IPV. Further, there is currently no national strategy informing a comprehensive response to IPV within New Zealand primary health care, allowing for extreme variation and potentially harmful responses to victims.

Objective of the research

I am seeking to understand what affects sustainable responses to intimate partner violence within New Zealand primary health care settings. Internationally, implementing a health system response to IPV has proven challenging, and the best approach is still unknown. Using an innovative theoretical perspective, my research will identify what interactions between the health care system and general practice influence sustainable responses to victims of intimate partner violence. This will highlight opportunities for influencing change within the health care system to inform better approaches to keeping New Zealanders safe from violence.

About this research

My PhD study builds on previous work conducted by the Interdisciplinary Trauma Research Centre at AUT University (see below references). Literature shows what components are needed to support effective responses to IPV in health care settings, but further research is needed to understand how complex health care system relationships can be utilised to support the sustainability of responses within primary health care. My PhD seeks to understand how interactions between the health care system and general practice influence and shape each other. To do this I will concurrently analyse documents which guide primary health care service delivery with regard to IPV responsiveness and interview key primary health care professionals from different general practices.

What will participants be asked to do?

GENERAL PRACTICE is participating in research which aims to support effective primary health care responses to intimate partner violence. As the Primary Health Organisation Manager of GENERAL PRACTICE, I would like to talk with you for 30 minutes about responding to intimate partner violence as a health issue.

Please note GENERAL PRACTICE does not have to be currently addressing IPV as a health issue for you to participate in the study. I am seeking to talk with different general practices to understand how a sustainable response to intimate partner violence might be achieved. As such, there can be no right or wrong opinions. You may like to accept a \$50 supermarket voucher to compensate for any costs incurred (such as loss of patient consultation time) by participating in this research.

What data or information will be collected?

Your interview will be recorded and transcribed by me. No identifying personal or organisational information will be used in any publication of the data. All information will be kept confidential, accessible only to myself and study advisors. However, individual participants within the same organisation will likely be aware of others participation in the study. The data collected will be securely stored. At the end of the study personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for ten years, after which it will be destroyed.

What are the benefits?

Your contribution to this research will help to inform effective, sustainable health care responses to New Zealanders who are experiencing violence. Research findings will fill a gap in international literature on how to best respond to intimate partner violence within primary health care and contribute to supporting the work of voluntary primary health care professionals who are actively responding to intimate partner violence in New Zealand.

The findings of my PhD study will be widely disseminated within Māori and primary health care communities as well as within academic health care journals and at national and international conferences. GENERAL PRACTICE will receive copies of publications and an invitation to the study findings presentation.

Confidentiality and Care

This research seeks to understand how the health care system can support effective, sustainable responses to IPV. I will not ask you about intimate partner violence experiences, patient or personal. I also recognise the competitive primary health care environment for resourcing initiatives which may or may not be Ministry of Health directed. This study does not ask GENERAL PRACTICE to initiate a response to intimate partner violence.

All information gathered will be treated as confidential. You may request to review your interview transcript. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. Each staff member participating in the study will be asked for their informed consent prior to being interviewed.

You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Information on preventing and intervening in family violence is available on the It's Not OK website (www.areyouok.org.nz). It's Not OK also provides a free helpline (0800 456 450) which can connect you to services that can help if you are experiencing or witnessing violence – or if you want to change your own behaviour. It is OK to ask for help.

How do I agree to participate in this research?

If you agree to participate in this research, please email the primary researcher Claire Gear - cgear@aut.ac.nz to schedule a 30-minute interview at a time that suits you.

If you have any questions please contact:

Please feel free to contact me or my supervisors if you have any questions about the research, now or in the future. I am happy to meet with you to discuss the study further.

Claire Gear, Doctoral Candidate
Interdisciplinary Trauma Research Centre, AUT University
Phone: 0273574845 Email: cgear@aut.ac.nz

Study Advisors:

Academic Supervisors:

Professor Jane Koziol-McLain
Centre for Interdisciplinary Trauma Research
AUT University
Email: jkoziolm@aut.ac.nz
Phone: (09) 921 9670

Dr Elizabeth Eppel
School of Government
Victoria University of Wellington
Email: elizabeth.eppel@vuw.ac.nz
Phone: (04) 463 7425

Primary Health Care Consultants:

Anna Rolleston, Director, Cardiac Clinic
Tauranga
Clare Healy, HaswellHealth, Christchurch

Cultural Consultant:

Tamati Tata, Huria Marae Tauranga

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Jane Koziol-McLain, jane.koziol-mclain@aut.ac.nz, (09) 921 9670.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Previous Research

Gear, C., Koziol-McLain, J., Wilson, D., & Clark, F. (2016). Developing a response to family violence in primary health care: The New Zealand experience. *BMC Family Practice*, 17, 115. doi:10.1186/s12875-016-0508-x

Gear, C., Koziol-McLain, J., Wilson, D., Rae, N., Samuel, H., Clark, F., & McNeill, E. (2012). Primary healthcare response to family violence: A Delphi evaluation tool. *Quality in Primary Care*, 20(1), 15-30.

***Approved by the Auckland University of Technology Ethics Committee on 1 March 2017
AUTEK Reference number 17/31***

7.10 Primary Health Organisation Manager Consent Form (revised)

What affects a sustainable response to intimate partner violence in primary health care?

Name of Organisation: _____

Name of Manager: _____

I have read the Information Sheet concerning this research and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any time.

- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (your choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that no identifying information will be used in any publication of the research.
- I agree to keep all information shared confidential, including the identity of the general practice.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature: _____

Name: _____

Phone: _____

Email: _____

Date: _____

**Approved by the Auckland University of Technology Ethics Committee on 1 March 2017
AUTEC Reference number 17/31**

Note: The Participant should retain a copy of this form.

Appendix C Interview Questions

IPV as a health issue

- Do you view IPV as a health issue for your patient population? Why/Why not?
- Has this changed over time? Why?
- Are you faced with needing to respond to IPV in your practice? *Probe: How are they currently responding to IPV?*
- Do you think the health setting is a place to respond to IPV? *Probe: primary or secondary?*
- Do you think the NZ health system supports responses to IPV? *Probe: primary or secondary?*
- What forms of support are needed to respond to IPV effectively? Who or where should these come from?
- Are you aware of the Violence Intervention Programme in your local District Health Board? Do you collaborate with Violence Intervention Programme? Why/Why not?
- What would you like to see happen in your organisation regarding responding to IPV?
- What do you think will challenge, or help, this to occur?

Who are you?

- Can you tell me who you are in the context of this organisation?
- How do you see your role in responding to instances of IPV that happen in your practice? *Probe: what influences you to work that way?*
- How are you different to others?

How do you work?

- Different professional and practice roles presumably have boundaries, and also overlap with each other. Can you tell me about how you see the particular boundaries of your role and the way your role overlaps with others?
- Can you tell me about how your role is enabled or constrained by these practices? *Probe: Can you think of any particular instances?*

How are you influenced by wider systems and practices?

- Are there wider systems or practices that influence how you might respond to IPV? Can you give me some examples? *Probe: internal? external?*
- Do you know how that practice or system influence began? *Probe: internal? external?*
- In what ways do you think your general practice's health focus differs from other health settings? *Probe: What enables or constrains this?*

Concluding Questions

- Any other comments?

Thank you for your time.

Appendix D List of documents analysed

Criteria for ‘Selected’ or ‘Secondary’

Selected documents are the most recently released policy, strategy, research or report document which directly influence responsiveness to IPV in New Zealand primary health care. Guided by question ‘What is the relevance of the document to the research problem and purpose?’ (Bowen, 2009).

Secondary documents are documents that may not be directly relevant to responding to IPV but provides context to help elicit document function such as ‘Why was the document produced? What are the assumptions within the text? How has this document been used by others?’ They may also provide further information on some of the key issues within the selected document (e.g. health system target effectiveness) Secondary documents may include commentary, research reports, websites, media releases. Secondary documents may also include previous editions of the selected document.

New Zealand health care strategies: Selected documents

Minister of Health. (2016). *New Zealand Health Strategy: Future direction*. Wellington, New Zealand: Ministry of Health. Retrieved from

<http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf>

Minister of Health. (2016). *New Zealand Health Strategy: Roadmap of actions 2016*. Wellington, New Zealand: Ministry of Health. Retrieved from

<http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf>

Ministry of Health Manatū Hauora. (2000). *The New Zealand Health Strategy*. Wellington, New Zealand: Ministry of Health. Retrieved from

<http://www.health.govt.nz/system/files/documents/publications/newzealandhealthstrategy.pdf>

Ministry of Health. (2001). *The primary health care strategy*. Wellington, New Zealand. Retrieved from <http://www.health.govt.nz/system/files/documents/publications/phcstrat.pdf>

Ministry of Health. (2014). *Statement of intent 2014 to 2018*. Wellington, New Zealand: Ministry of Health.

The Royal New Zealand College of General Practitioners. (2016). *Aiming for Excellence: The RNZCGP standard for New Zealand general practice*. Wellington, New Zealand. Retrieved from <https://oldgp16.rnzcgp.org.nz/assets/New-website/Quality/Aiming-for-Excellence-20-Sept-2016-FINAL.pdf>

New Zealand Health Care Strategies: Secondary Materials

Bogsnes, B. (2017, 23 January). Hitting the target but missing the point - myths about target setting. Retrieved from <http://www.managementexchange.com/hack/hitting-target-missing-point-myths-about-target-setting>

Gauld, R. (2008). The unintended consequences of New Zealand's primary health care reforms. *Journal of Health Politics, Policy and Law*, 33(1), 93-115.

Gauld, R. (2014). What should governance for integrated care look like? New Zealand's alliances provide some pointers. *Medical Journal of Australia*, 201(3), S67-S68. doi:10.5694/mja14.00658

Gauld, R. (2016). Healthcare system restructuring in New Zealand: problems and proposed solutions. *Asia Pacific Journal of Health Management*, 11(3), 75-80.

Gauld, R. (2017). The theory and practice of integrative health care governance: The case of New Zealand's alliances. *Journal of Integrated Care*, 25(1), 61-72. doi:10.1108/JICA-10-2016-0035

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