April 2014 BRIEFING PAPER 1

The first in a series of briefing papers outlining research from the PROVIDE research programme.

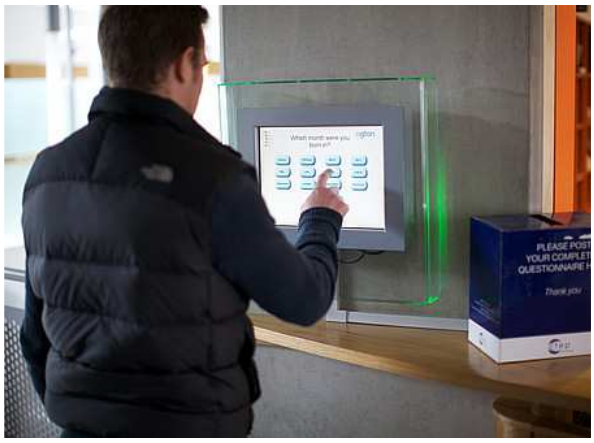
Asking men about domestic violence and abuse (DVA) in a GP setting.

Recruitment and Participation.

This paper is concerned with the methodological challenges of recruiting male patients in general practice to research about domestic violence and abuse (DVA). From October 2010, 2431 eligible male patients were approached and asked to complete a survey about their experience of DVA as victims and/or perpetrators in 16 general practices in the South West of England. 1430 men completed part one of the survey, 59% of those who were approached. This paper presents the recruitment figures from each of the practices involved in this study as well as a flow chart showing the aggregated recruitment figures. This recruitment data is compared with other studies which have been designed to ascertain the prevalence of DVA within male and female health populations. This paper will be of interest to those recruiting male patients within general practice, and in particular to those interested in asking questions about personal issues such as DVA.

Keywords: domestic violence; male victims; health research.

This study, with men in general practices, builds on previous pilot research conducted in four GP practices in the North East of England (Westmarland et al, 2004) which found that 14% of male patients surveyed in these general practices experienced potentially violent or abusive behaviour by a partner or someone at home, and 16% self-identified as having perpetrated violence against a partner or someone at home. The majority (75%) of male patients involved in that research thought it was helpful for men to be routinely asked about abuse. This research (Westmarland et al, 2004) also showed that 32 (out of 45) male perpetrators interviewed had been to their GP to ask for help prior to attending a domestic violence perpetrator programme.



This previous research suggests that general practice may be an appropriate setting in which to identify potential male victims and perpetrators of DVA. Yet we know little about the nature, impact, or extent of male patients' experiences and perpetration of abuse. The current study aims to address this knowledge gap.

To achieve this aim, it was necessary to recruit male patients to answer questions about their personal and intimate relationships. The current study addresses how men both experience and may perpetrate negative relationship behaviours which may (or may not) be considered abusive. It involves a cross-sectional survey of male patients to investigate prevalence, plus follow-up interviews with a self selected sample. In this paper we report the ethical and methodological issues that arose in the recruitment of male patients within a GP setting as well as the recruitment figures across the different general practices. A further study was conducted by the research team, using the same methodological approach, to recruit men attending sexual health clinics, but this briefing paper focuses on the recruitment of men within general practice only.

Asking patients to participate in research about DVA

Over the past ten years there has been a growth in the number of studies which have asked both men and women about their experiences of DVA in a range of settings. These studies include primary and secondary analysis of nationally representative surveys examining the prevalence of abuse (Brieding, 2008; Smith et al, 2010; Tjaden and Thoennes, 2000; Grande et al, 2003; Watsons and Parsons, 2005; Slashinski et al, 2003; Williams and Frieze, 2005) as well as the analysis of samples from the criminal justice system (Henning et al, 2005; Hamberger and Guse, 2002), and domestic violence helplines (Hines et al, 2007). Whilst these studies discuss the composition of their samples in terms of experiences of abuse, few report details of recruitment methods: the ways in which potential participants were approached, response rates, and the reasons why potential participants, male and female, might have chosen not to take part in research.

Richardson et al (2002) in a study conducted within the London Borough of Hackney, were able to consent 64% of the 2192 eligible women who attended the practice during the studies recruitment sessions. Of these, 1207 (55%) were both consented and completed the survey (Richardson et al, 2002).

In the same year, Bradley et al (2002) reported on their study conducted in general practice in Ireland. They reported that reception staff gave questionnaires to 63% of the eligible 4134 women who attended the participating practices. Of the 2615 women given the questionnaire 1871 (72%) participated. This team reported a response rate ranging from 38% to 95% across the 22 practices who took part with a median response rate of 79% and a mean of 72% (Bradley et al, 2002). Receptionists responsible for the distribution of the questionnaires reported a number of reasons why women were not asked to take part. These included: women who had already been asked, women were elderly, or the woman was accompanied.

Hegarty and colleagues (2011) conducted a domestic violence survey in general practice in Australia with female patients and of the 2338 eligible women in their study, 78.5% (N=1836) completed the survey. This ranged within the different general practice surgeries from 58% to 95.6% of eligible participants.

French and Freel (2009) in the Northern Ireland Crime Survey module on sexual violence and abuse reported a response rate of 69%.

However they do not identify whether this response rate differed according to gender.

In relation to the recruitment of male patients, Oriel and Fleming (1998) conducted a cross-sectional survey of male patients regarding perpetration of domestic violence within three family medicine clinics. They reported that 375 male patients attended the 3 clinics on recruitment days, of whom 85% (N=317) participated. However, they go on to identify that only 237 of those who participated were eligible.

Methodology

The recruitment of men in general practices for the current study was conducted in urban and rural localities in the south west of England between October 2010 and June 2011. We aimed to recruit a total of 1400 men from 14 general practices which were stratified by ethnicity, urbanity/rurality, and socioeconomic status and randomly selected to match the national demographic profile of general practices. Consecutive un-accompanied male patients were approached by an experienced researcher in GP waiting rooms and asked to participate in a survey entitled *Health and Relationships*. All aspects of the study were scrutinised by a local NHS Research Ethics Committee and approval granted. In addition the relevant NHS R&D governance checks were made including the provision of NHS Research Passports for the recruiting researchers.

The Survey

Further information about the design of the PROVIDE Survey is available in briefing note 2. Of relevance to the recruitment of participants was the fact that the survey was split into two distinct parts.

The first part included sections which asked about: socio-demographics; general health and well-being; experience of, and perpetration of, potentially abusive behaviours; help-seeking; attitudes to being asked about abuse; and potential impacts of potentially abusive behaviours. It took participants approximately 10-15 minutes to complete part 1 of the survey.

Part two of the survey contained more detailed questions about negative relationship behaviours which may be interpreted by respondents as abusive. Much of the research which has examined the prevalence of domestic violence amongst male victims has failed to adequately include impact alongside the extent of potentially abusive behaviours respondents have experienced. Research with heterosexual men has also problematised the distinction between men who are victims and those who may also be engaging in abusive behaviours against their partners (Gadd et al, 2002). The development of the measure was intended to address both of these concerns. Part two of the survey therefore contained a number of scales which asked whether participants had experienced or perpetrated up to 51 (27 emotional, 14 physical and 10 sexual) potentially abusive behaviours both within the past 12 months or previously. For each of the sub sections questions were asked about the impact of this experience. These scales were drawn from the previously validated COHSAR survey tool (Hester et al, 2010). Due to the sensitive nature of these questions a further warning was given at the start of Part Two, advising that some respondents might find completing these more detailed questions upsetting.

After completing the survey, men were offered a list of help services (phone numbers and websites) for both male victims and perpetrators of DVA, if they felt it was safe to take away.

Recruitment of practices

The randomly selected general practices were approached by letter via the south west Primary Care Research Network (http://www.wren.soton.ac.uk/west.htm). Each practice was sent an initial invitation and contacted shortly afterwards by the research team to answer any questions. Four practices declined to take part and were replaced by practices within the same sampling stratum. Service Support Costs that reimburse the expenses of practices participating in research were paid to study practices. Generally the 100 men could be recruited within three weeks but in small practices recruitment proved slow, and additional practices from the same stratum were required to supplement them. To illustrate these differences, recruitment rates are provided in table 1 (below) for the 16 practices taking part in the research.

Study practices had a number of queries about the research. Primarily, practices were concerned about the potential impact of the research within the practice. This related to both practical arrangements (such as whether a room was available) as well as concerns about the subject of the research. For example, some were concerned that patients might raise additional issues relating to DVA having completed the survey prior to visiting the clinician. The extensive experience of the research team in conducting domestic violence research was important in allaying the fears of practitioners and to assure them that participants could be dealt with appropriately by the researchers. This mainly involved signposting participants to relevant local and national services.

Approaching potential participants

Consecutive men attending the general practices were approached by an experienced researcher if they came into the general practice alone, looked over 18 (if we were unsure we asked), and were waiting for an appointment. They were informed that the research team was conducting research with male patients in GP practices about how relationships might affect men's health. Potential participants were given the option of two levels of consent: just consenting to complete the survey or consenting to complete the survey and allowing access to their medical records. All the researchers had received the relevant ethical and governance checks prior to commencing fieldwork in the practices, including obtaining NHS research passports. All were female. Participants who filled in the questionnaire were also asked if they were willing to take part in a follow-up interview.

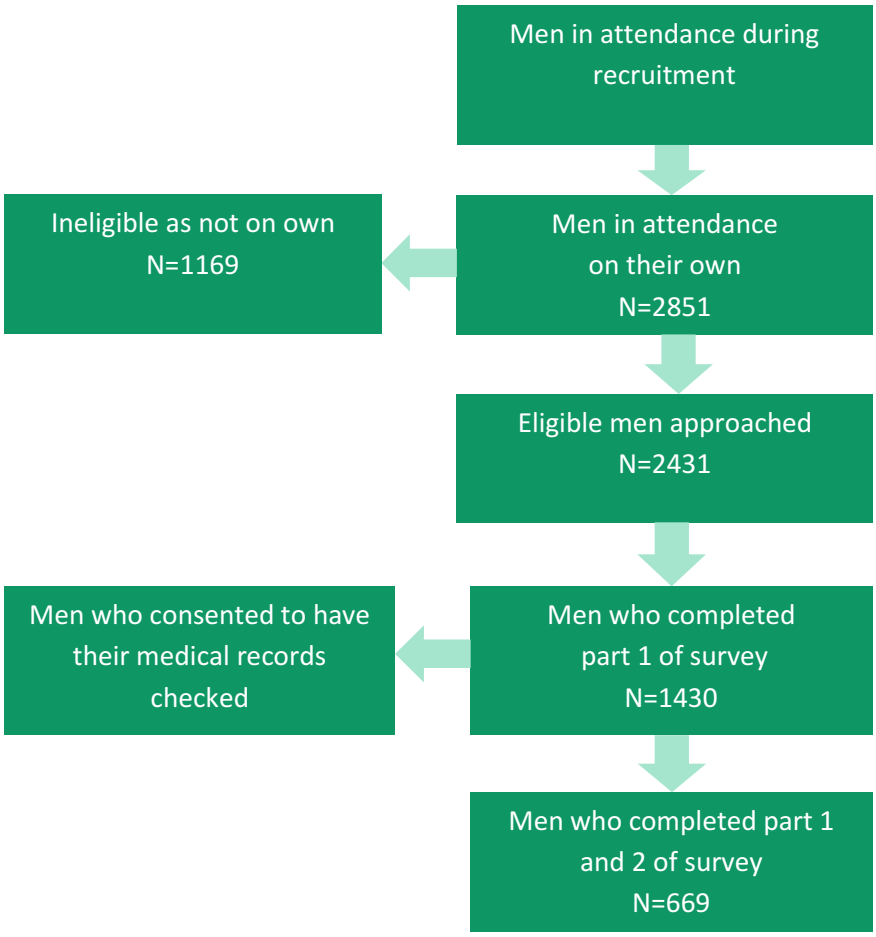
Findings: Recruitment of participants

Recruitment rates within GP practices varied from an average of 3 men completing at least part one of the survey per 3-4 hour session to 7 men recruited per session. Each researcher recorded: the number of men who came into a practice; how many were on their own and therefore eligible for inclusion in the study; how many were approached; and how many men declined to take part. Table 1 below illustrates these data across the different practices. Figure 1 presents the aggregated data in the form of a recruitment flow-chart.

Table 1: Recruitment rates cross the study

ID	Total number not on own [average per recruitment session]	Total number on own [average per recruitment session]	Total number who were approached [average per recruitment session]	N = Men who completed at least part 1 of survey (% of those approached)	N = Men who completed part 2 of survey (% of those approached)	N = Men who agreed to access to medical records (% of those who completed at least part 1)	No. of sessions
14	241 [13]	289 [15]	247 [13]	108 [44%]	43 [17%]	17 [16%]	19
19	112 [9]	261 [22]	176 [15]	102 [58%]	76 [43%]	13 [13%]	12
16	149 [15]	235 [24]	172 [17]	98 [57%]	27 [16%]	17 [17%]	10
18	84 [9]	86 [10]	78 [9]	27 [35%]	7 [9%]	2 [7%]	9
26	78 [9]	157 [17]	140 [16]	77 [55%]	24 [17%]	40 [52%]	9
21	123 [8]	174 [12]	155 [10]	107 [69%]	54 [35%]	47 [44%]	15
13	140 [9]	248 [16]	232 [15]	94 [41%]	59 [25%]	38 [40%]	16
15	33 [3]	160 [12]	138 [11]	100 [72%]	54 [39%]	29 [29%]	13
17	87 [6]	185 [13]	162 [12]	104 [64%]	46 [28%]	53 [51%]	14
22	76 [5]	82 [5]	74 [5]	53 [72%]	30 [41%]	25 [47%]	15
23	51 [10]	75 [15]	69 [14]	50 [72%]	11 [16%]	8 [16%]	5
11	129 [7]	192 [11]	174 [10]	100 [57%]	42 [24%]	48 [48%]	18
27	98 [10]	176 [18]	144 [14]	102 [71%]	65 [25%]	52 [51%]	10
20	62 [3]	159 [8]	147 [8]	104 [71%]	40 [27%]	57 [55%]	19
12	81 [5]	168 [9]	148 [8]	102 [69%]	54 [36%]	45 [44%]	18
28	124 [14]	204 [23]	175 [19]	102 [58%]	37 [21%]	54 [53%]	9
	1668	**2851**	**2431**	**1430 [59%]**	**669 [28%]**	**545 [38%]**	**TOTAL**

Figure 1: Flow chart of aggregated recruitment

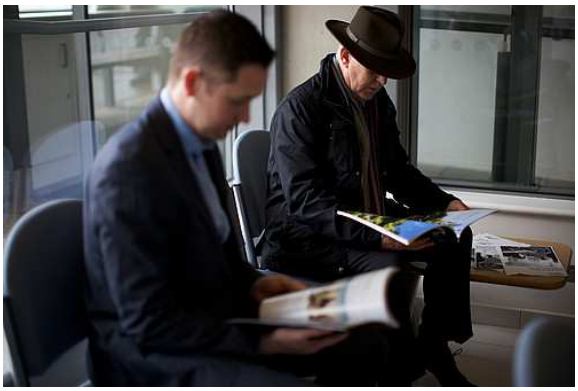


Eighty five percent of eligible men were approached by researchers. Of the 2431 men who were approached and asked to complete the survey a total of 1430 (59%) completed part one, and 669 (28% of those approached) completed both parts one and part two of the survey. The recruitment rate at each practice ranged from 35% to 72% of men who were asked to complete the survey who agreed to do so. Of these 1430 men, 545 (38% of those who completed at least part of the survey) gave consent for the research team to look at their medical records.

Impacts on recruitment

In addition to two sites where the survey was successfully piloted, 16 general practices took part in the research. Each practice was different and presented different challenges. For example, the researchers were located within the waiting room of practices which differed in their layout and size. It was helpful for the researcher to be able to see men entering the practice and registering their attendance for an appointment, particularly where two practices shared the same waiting room.

Some practices had touch screens to log attendance whilst others did not. Where there were large queues for booking in with reception it was not always easy for the researcher to ascertain whether a male patient was attending on his own or not. In some cases a man would sit down on his own before being joined by a friend, relative or partner. Long queues at reception desks reduced the amount of time available for respondents to complete the survey whilst waiting for their appointment. Practices also differed in the appointment system they used and how these were implemented. Some practices had highly efficient reception teams who only dealt with patients coming into the practice, whilst others used these staff to both respond to patients in person and on the telephone. Where appointment systems were efficient, researchers had a longer window of opportunity within which to approach potential participants before they were called into their appointments.



The layout of seating in the waiting area could affect whether it was always appropriate to approach individual men. For example, one practice had the seating so close together that at busy times it would jeopardise confidentiality to ask them to complete the survey.

As can be seen from the recruitment data, not all of the male patients who were eligible to take part were approached. There were a number of reasons for this. The largest group were those men who were called in to see the GP before the researcher had an opportunity to approach them. There were also specific incidents within practices which meant that patients were not approached. This included incidents where patients were arguing loudly with reception staff, where patients passed out/fainted, or where patients were deemed to be agitated or too severely ill to be approached. A decision was also made at the advisory group meeting that if a researcher was not sure of the gender of the participant they would not be approached (this occurred in two cases).

The researchers found that men approached to take part were generally positive. However a minority of men were not happy about being asked to complete the survey and in some cases were hostile. Where it was possible for the researcher to record this information in file notes they did so. Comments received by the researchers included: “I can’t be bothered”; “Go away”; “It’s private/none of your business”; “I don’t do surveys”; “I’ve got far more important things to do”; and in a few cases potential respondents completely ignored the researcher when they were approached. Some patients stated that they hadn’t brought their glasses with them and although a larger print version of the survey was available in some cases it was clear that this statement indicated they did not want to take part.

There were some men who explicitly stated that they either could not read and write and therefore did not want to take part, or would need help to complete the survey. In some cases, the researcher then assisted with completion of the survey (it was possible to record this on the survey and will be taken into account in the analysis). However, due to the sensitive nature of the questions, it was often not appropriate to do so without adjourning to a private room. Other reasons for men declining to take part included that they were unable to hear our invitation to participate due to hearing problems, or they were physically unable to write (for instance if their arm was in plaster).

Those practices with a lower recruitment rate had far fewer male patients attending and those who did attend were not always eligible. To be eligible for the survey, male patients needed to be attending on their own and in some practices this was an issue. For example, given that GP surgeries are area-based, it is often the case in smaller communities that patients know one another and therefore sit together to catch up even if they are attending the surgery on their own. In addition, men would often be accompanied to the practice by their partner or friends. This was often an issue in some of the inner city practices where there appeared to be higher levels of patients with substance misuse issues attending on a regular basis for their prescriptions. Very often these men would come to the surgery with a friend or in groups.

The punctuality of appointment times also impacted on recruitment as men might not have time to complete part one of the survey before being called into their appointments. However we were pleasantly surprised that a large number of men offered to finish the survey after their appointment. Many of those called in before they had time to start their survey offered to take it away and return it to us. We had made a decision prior to the research starting that this would not be appropriate in case it was not safe for them to take the survey home. They appeared to understand this reason and were grateful that the same concern was applied to the safety of male patients as to female patients at risk of abuse.

Due to the sensitive nature of some of the questions we were aware that some respondents might find it upsetting to complete the survey. As a result each practice provided a space where the researcher could discuss in a more private setting the services available to men who are experiencing or perpetrating DVA. This resource was only used five times. In these cases the participant, rather than wanting to talk about current abuse, wanted to discuss issues relating to past abuse (sometime related to witnessing or experiencing abuse as a child).

Discussion

This study successfully recruited 1430 out of 2431 eligible male patients approached to take part, a response rate of 59%. This is a higher rate than in a comparable study of 1207 women recruited in 11 general practices in east London (Richardson et al 2002) with a response rate of 55% and lower than the revised response rate of male patients recruited by Oriel and Fleming (1998) which was 85% (although not all of those recruited and reported on were eligible). However, Oriel and Fleming were recruiting in only 3 family medicine clinics which gave them more control over their environment. As this paper has described, recruitment in the current study took place in 16 different general practices, all of which brought their own practical issues. Taking these factors into consideration, the 59% response rate achieved in this study can be seen as a useful benchmark for the recruitment of male patients in this kind of research.

There are however, also lessons which can be learnt and positive recruitment practices which emerged during the recruitment for this study which could help others in the design and implementation of methods in this area of research. Firstly it was important to address issues of safety.

The over-riding principle for such a survey is to 'do no harm'. Possible dangers to men who may be victimised by a partner should be anticipated and eliminated, as should the possibility of invoking perpetration.

This may involve: only approaching men who attend on their own, offering all a helpsheet (if it is safe to take away with them), not asking the survey questions in a public place for men who cannot read or write well enough to fill in on their own, not allowing men to take the survey out of the surgery to complete at home.

The second issue was privacy. Men completing the survey should feel confident that others cannot read their answers, which may mean stopping the survey at busy times, and if possible finding more private spaces (such as in an adjoining room). Thirdly, as answering the questions could trigger upsetting memories of abuse, all participants were offered the chance to talk to a researcher in private afterwards, although very few took advantage of this. Others could have contacted organisations listed on the helpsheet.

The fourth issue related to the questionnaire structure. It proved useful to divide this into two sections. Everyone was asked to answer a relatively short section concerning demographic and health information and a few key questions about experiencing or perpetrating domestic abuse. The more detailed section about a large number of possibly abusive behaviours (emotional, physical and sexual) was optional and prefaced by a warning that some might find the questions 'difficult' to answer.

And finally, to encourage completion of a long questionnaire, it was vital that it was as attractive, easy-to-read and easy-to-complete as possible. We used an A5 booklet format, with large font (for Part 1), mostly tick-boxes and much 'white space'. Part 2 included answering 101 questions about experience and perpetration of negative behaviours for two time-frames. However many men only answered for one time-frame, so this may be a more realistic option in this context.

Conclusion

Many men were surprised to be asked to complete a survey, which included questions about relationships. This reaction proved a useful tool in recruitment, explaining why it was important to be conducting research in this area. The majority of those approached could see the benefit in their experiences as men being better known and understood through research. However, some men were hostile to being asked to complete this survey, a response which the researchers have not previously encountered when asking women about relationship issues and domestic violence. It will be interesting to see how men have completed the survey question which relates to being asked about relationship issues within a general practice context.

This study successfully recruited over 1400 men in general practices to complete a survey looking at experience and perpetration of domestic violence. The study identifies a number of factors which influenced recruitment. This included the need to apply the same ethical and practical considerations with this group as one would when researching female victims of domestic violence. Most of the participants took the support service helpsheet they were offered and presenting it to them as either for themselves or 'someone they know who might benefit' was a sensitive way in which to present this information. Finally, despite the fears of some of the practices about the impact the research might have on their clinical interactions with patients, no adverse affects were reported during the course of the research.

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