# The Navigator approach to Domestic Abuse

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# Abstract

Intimate Partner Violence (IPV) is a global public health problem that impacts victims' emotional and physical wellbeing and costs health care systems in Scotland an estimated £2.3 billion annually (Scottish Government, 2009). Many personal, social, and structural factors often lead to repeated instances of violence in victims' lives and create barriers to the health and wellbeing of victims and their loved ones. Hospital Based Violence Intervention Programs (HVIPs) have emerged as a way to end the cycle of violence by supporting victims in moving away from violent lifestyles. The objective of this study was to examine if and how the Navigator programme, a Scottish HVIP is helpful to victims of IPV.

This study used semi-structured interviews to highlight the perspectives of those who have engaged with the Navigator programme, either as service providers or service users.

Overall the data suggested that the Navigator programme was extremely beneficial to victims of IPV and their loved ones as they recovered from traumatic experiences. The major weakness of the Navigator programme was the limited reach of the service due to small numbers of caseworkers. The results of this study provide a glimpse into how the Navigator programme impacts survivors of IPV and their families and what may be needed to improve the service in the future.

# Introduction

Intimate partner violence (IPV) has devastating impacts on both victims of abuse and the social services systems that aid them (Lipsky et al., 2006; Bybee & Sullivan, 2002). The economic burden of IPV in the United States alone is estimated to be at roughly 6 billion dollars annually (Lipsky et al., 2006). In Scotland that figure was estimated at £2.3 billion (Scottish Government, 2009). Hospital-based Violence Reduction Intervention Programs (HVIPs) have been successful in reducing violence, hospital recidivism, and involvement with the criminal justice system by helping victims to make sustainable changes to their behaviours and lifestyles (Chong et al., 2015; Snider et al., 2010). Several researchers have recommended that HVIPs be implemented in every emergency department as part of routine emergency care (Purtle et al., 2015). This could be especially advantageous for victims of intimate partner violence (IPV), who often encounter extra barriers to ending the cycle of violence in their lives (Fugate et al., 2006). However, more evidence is necessary to determine how HVIPs specifically help victims of IPV move away from violent lifestyles so that they can live safer and healthier lives.

The Navigator program is an HVIP operating in two cities in Scotland (Edinburgh and Glasgow). The purpose of this study will be to determine how the Navigator programme helps victims of IPV move away from violent lifestyles toward a healthier, sustainable lifestyle that is free from violence. Few studies have evaluated the outcomes of HVIPs for service users who have experienced IPV. The aims of this research will be to conduct a qualitative evaluation of the Navigator program to determine how it facilitates people in moving away from IPV and chaotic lifestyles. Some objectives will be to evaluate the extent to which participants feel supported in their attempts to move away and recover from violent lifestyles; to ascertain any negative impacts the Navigator program has on participants and their communities; to identify strengths and weaknesses of the intervention from the

perspectives of service users and service providers; and to create a basis for future research and planning for violence reduction in Scotland; (Taylor et al., 2005).

The research questions of this study will be as follows:

**RQ1**. How acceptable is the intervention to members of the target group (victims of IPV) and practitioners (Navigators and members of partner organisations)?

**RQ2**. How do different members of the target group respond to the intervention (especially victims who are not women partnered with men)?

**RQ3**. Are the causal mechanisms operating as intended?

**RQ4**. Are there any unintended consequences of the intervention?

Structure of the Research

Chapter two will consist of the literature review and will discuss the existing literature on the problem of IPV, including its burden on the health of victims and their families, as well as on social care systems. Next it will discuss how HVIPs function and how they help to end the cycles of violence and repeat injury. This chapter will also explore how the targeted social support provided through HVIPs helps to build service users' resilience so that they can make lasting changes to their lifestyles. Finally, included in this chapter will be a description of the specific HVIP on which this study will focus, the Navigator program. Chapter three will outline the methodology and limitations of this study. Here I will discuss sampling and participant recruitment, as well as my reasons for choosing a qualitative approach to this study. Included in the Methods section, I will also discuss the role of the researcher, my particular standpoint, and how the research affected me. The fourth chapter will consist of the analysis of the findings using framework analysis to interpret data gathered during interviews with service users and service providers. The final chapter will consist of concluding remarks and will outline the most salient findings of this study.

# Literature Review

Understanding the Problem of Intimate Partner Violence

Violence is becoming more accepted as a public health problem that has widespread implications for physical and mental health, community safety, public policy, and human rights globally (Cooper, Eslinger, & Stolley, 2006; Garcia- Moreno et al., 2013; WHO, 2002; Purtle et al., 2015). Despite the World Health Assembly recognizing the urgency of preventing violence, especially gender-based violence in 1996, and the United Nations prioritising the end violence against women and girls in the Sustainable Development Goals, many governments still have not taken measures to address the issue of violence against women as the serious, and often deadly public health and human rights problem that it is (Garcia-Moreno et al., 2013; UN, 2015). Scotland, and Glasgow in particular, have been known for especially high rates of violence as compared to its UK and European counterparts (Gilchrist et al., 2017).

Intimate partner violence (IPV), in particular, is a form of violence that impacts every community across the globe. For the purposes of this study, IPV is defined as "a pattern of assaultive and coercive behaviours including physical, sexual, and psychological attacks, as well as economic coercion that adults or adolescents use against their intimate partners," (Bent-Goodley, 2007, 91). It is estimated that, globally, as many as 30% of women experience IPV (Loxton et al., 2017; Scott, 2015). In Europe, 22% of women are estimated to have experienced IPV by the time they reach 15, while in the United Kingdom, the prevalence of physical or sexual IPV is estimated to be 29%, and the prevalence of psychological IPV in the UK is 46% (Scott, 2015). According to the Scottish Government (2009), nearly half (45%) of all rapes reported in the 2002 British Crime Survey were perpetrated by the victim's intimate partner. In recent years the number of incidents of IPV in Scotland has remained fairly stable at 58,000- 60,000 per year, although in 2014-2015 the

number of reported incidents of IPV rose by 2.5% from the previous year, 79% of which involved a female victim and a male perpetrator (Scottish Government, 2018). However, there has been an increase in the reported incidence of IPV in which there was a male victim and a female perpetrator (Scottish Government, 2017). According to various studies, emotional abuse is the most common form of IPV, followed by physical abuse, although emotional and physical abuse often occur together. Data also show that experience of emotional abuse is often predictive of future experience of physical forms of IPV (Kuijpers, van der Knapp, and Lodewijks, 2011).

The Public Health Burden of IPV

There are a multitude of studies that link IPV with negative physical and mental health outcomes (Bonomi et al., 2006; Loxton et al., 2017; Horon and Cheng, 2001; Campbell, et al., 2003). IPV is a leading cause of injuries among women, and women who experience IPV are twice as likely to be in poor health as women who have no history of IPV (Bonomi et al., 2006; Bent-Goodley, 2007). Health effects of IPV include injury, psychological trauma and Post Traumatic Stress Disorder, depression, anxiety, fearfulness, suicidal ideation and suicide attempts. Adverse mental health effects can, in turn, contribute to drug and alcohol abuse, cardio vascular disease, and somatic symptoms such as irritable bowel, insomnia, chronic pain, and chronic pelvic pain, among others. Perpetrators of IPV often exert control over their victim's body and resources, reducing victims' autonomy and abilities to make decisions. Victims of IPV are often unable to ensure safe, or consensual sex practices, leading to heightened risk of sexually transmitted infections, unplanned pregnancies, abortion, and difficulty seeking medical treatment (Bent-Goodley, 2007; Bogat et al., 2005; Bonomi et al., 2006; Burke et al., 2001; Scott, 2015; Abdollahi et al., 2015; Loxton et al., 2017, Coker et al., 2002; Swan and O'Connell, 2012). Especially in cases of chronic violence, a victim's

capacity to care for themselves and their families can also be compromised, often leading to specifically damaging outcomes for young children (Fathalla, 2005). Up to 50% of all incidents of IPV that are reported were witnessed by children (Wortham, 2014). Much evidence has shown that children exposed to IPV often manifest various dysfunctional behaviours, including low academic performance, bullying, and weakened ability to form healthy relationships as adults (McDavid, Cowell, & McDonald, 2011). Further, some studies suggest that up to 50% of men who frequently abused their partners were also likely to abuse their children, and that mothers who experienced IPV were more likely to abuse their children than mothers who had not experienced IPV (Frasier et al., 2001).

Among the most devastating health outcomes of IPV is death (Al Dosary, 2016; Scott, 2015; WHO, 2011). Femicide, defined as the killing of women because they are women, has been identified as the seventh leading cause of death for women globally (Brennan, 2016; Campbell et al., 2003; Shandingian and Bauer, 2005). The United Nations Office on Drugs and Crime (UNODC) found that women were significantly more likely than men to be killed by an intimate partner (Campbell et al., 2003). Evidence suggests that globally, up to 44% of femicides are committed by a woman's partner, or ex-partner, whereas between 3% and 6% of male victims of homicide are killed by their intimate partner (Bent-Goodley, 2007; Brennan, 2016). Studies have also shown that up to thirty-seven per cent of women admitted for treatment in emergency rooms are there for IPV-related injuries, (Bent-Goodley, 2007). Despite these grim statistics, few women presenting in emergency rooms for violent injuries are asked about, or volunteer information about being in a violent relationship (Frasier et al, 2001; Garcia, 2004; Houry, et al., 2008; Schrager et al., 2013).

IPV is an epidemic that affects individuals from every demographic background and causes devastating consequences for public health (Wortham, 2014; Kishor, 2005). While no one is immune to IPV, a person's social position can often render them more vulnerable to

this form of violence. People of lower socioeconomic status, those with less education, younger people (aged 15-45), disabled people, homeless people, those with insecure migration status, women, and transgendered people are often at higher risk of exposure to IPV (Abdollahi et al., 2015; Scott, 2015; Snider et al; 2016). Experiences of IPV are often compounded by the intersections of victim's multiple identities and the various patterns of oppression that come with the subject positions that victims occupy (Bent-Goodley, 2007). In many cases, members of the lesbian, gay, bisexual, and transgender (LGBTQ) communities have been neglected by studies of IPV, which tend to focus most of their attention on women in heterosexual partnerships (Ard and Makadon, 2011). This is problematic, as studies of IPV in LGBTQ partnerships have indicated that IPV occurs at the same, or higher rates as it does in heterosexual partnerships, and that 21% of men and 35% of women who had ever cohabited with a same-sex partner, as well as 34.6% of transgender individuals reported experiences of IPV (Walters, Chen, and Brieding 2013; Ard and Makadon, 2011; Houston and McKirnan, 2007). Regardless of the gender of their partner, men have been found to be significantly less likely than women to report their experiences of physical or sexual IPV due to societal attitudes surrounding masculinity (Coker et al., 2002). To complicate matters further, many services for victims of IPV, such as domestic violence shelters and crisis centers only provide services for women and those who identify as women (Ard and Makadon, 2011).

The severity of IPV's impact on the health of victims, as well as its extremely high prevalence make it a global public health issue of paramount importance. Thus, it is necessary that effective interventions be available for the growing number of people who are in need of services. However, more studies on the development, implementation, and evaluation of intimate partner violence interventions, specifically HVIPs are necessary (Bonomi et al., 2006; Burke et al, 2001).

Stages of Change

Many believe that unhealthy behaviours are often the cause of violent lifestyles, chronic illness, excess death, and increased healthcare spending, and that the most effective way of reducing risky behaviours is to develop interventions based upon research on behaviour change (Prochaska, Wright, and Velicer, 2008). As was stated by Young (2018), the theory that underpins the Navigator program is based on the Stages of Change (SOC) model, also sometimes referred to as the Transtheoretical Model, as it incorporates aspects of several previous models of behavioural change (Prochaska & DiClemente, 1983; Stoever, 2011). While there has been criticism of the SOC model, it has been validated by numerous studies and is widely accepted within the psychological community (Stoever, 2011). The Stages of Change model holds that behavioral change is not a static process, but is more often dynamic and cyclical. The SOC model maintains that, because individuals will differ in their readiness to change their undesired behaviors, change often occurs in stages over time. Rather than suggesting that people will always progress through the stages in a linear fashion, the SOC model leaves a great deal of room for individuals to relapse to previous stages in their journey toward behavior change. This model has been successfully applied to studies of smoking cessation, weight loss, alcoholism, and victims of IPV who attempt to end their relationships. The SOC model has helped to illuminate the fact that both people attempting to stop smoking and those attempting to end abusive relationships are often only successful after several cycles of progress and relapse (Littell and Girvin, 2002; Schrager et al., 2013; Sleet and Gielen, 2008; Stoever, 2011).

Responsibility for violence rests solely with the perpetrators of IPV. As such, some have suggested that interventions aimed at curtailing partner violence should target abusers, rather than victims. However, interventions for rehabilitating perpetrators of IPV have shown limited success, further underscoring the need for interventions designed to increase victims'

agency in ending their own abuse (Foa et al, 2000; Kuijpers, van der Knapp, and Lodewijks, 2011). While many victims of IPV do eventually leave their abusive partners, it is often after several unsuccessful attempts that they are finally able to end the relationship and move forward (Foa et al., 2000; Sleet and Gielen, 2008; Stoever, 2011). Advocates of the SOC model point out that it differs from many other models developed for understanding the dynamics of abusive relationships in that it seeks to explain the strategies IPV survivors use to end violent relationships over time, rather than focusing on behaviors and tactics employed by abusers (Stoever, 2011). The SOC model also allows for a more compassionate view of victims of violence who may not be ready or able to leave their abusive partner, as opposed to blaming the victim, because it normalises the process of progress and relapse between stages (Littell and Girvin, 2002). Every survivor of IPV will have had different lived experiences, and will have different strategies for coping with violence, and so the process of ending a violent relationship is one that can never be the same from one individual to the next (Stoever, 2011). Many believe that the SOC model can be useful for developing and implementing interventions tailored to the needs of individual service users. This requires a collaborative relationship between the service user and the case worker, as they must work together to identify where to begin treatment based on what stage in which service user perceives themselves to be (Freeman and Dolan, 2001). As Sleet and Gielen (2008), point out:

> Identifying an individual's stage of change allows the practitioner to select and apply the most appropriate, stage-matched intervention. For example, increasing knowledge and awareness may help someone progress from the pre-contemplation to the contemplation stage. To move someone from contemplation to preparation and action may require identifying, providing, and facilitating access to and use of the necessary resources (402).

Basing a service user's treatment plan on their individual stage, or their level of readiness to change is thought by many to be a much a much more effective way of promoting behavior

change than the traditional action-based methods that have been applied to behavior change interventions in the past (Littell and Girvin, 2002).

Critiques of SOC

While the Stages of Change model has been widely acclaimed for its applicability to a wide range of populations and problems (Littell and Girvin, 2002; Prochaska, Wright & Velicer, 2008), others have been critical of the SOC model. Some critics of the SOC model suggest that it "oversimplifies the complexities of behavioral change by imposing artificial categories on continuous processes" (Littell and Girvin, 2002, 225). Several critics have taken issue with the suggestion that victims of violence progress in a linear fashion through distinct stages to reach sustainable change (Schrager et al., 2013). Not only can it be difficult to define actions that would place victims within a specific stage, but victims often progress, then regress, and even skip stages entirely on their journeys toward lasting behavioral change (Schrager et al., 2013). Further, even after victims of violence are ready to change their lifestyles, their ability to do so is often impeded by external factors such as increasing severity of IPV, controlling behavior by their partner, lack of time, lack of resources and access to services, lack of social support, etc. (Fugate et al., 2005; Schrager et al., 2013). HVIPs can help to address these external factors that too often impede victims' ability to recover and lead safer and healthier lives free from violence.

What are HVIPs ?

Violent injury and reinjury represent a public health crisis that incurs huge costs to communities in both social and economic terms (Affinati et al, 2016; Chong et al., 2015; Dicker, 2016; Noori, 2017; Smith et al., 2013; Purtle et al., 2013). In many cases, victims of interpersonal violence will be discharged from the hospital only to return to the environment

that contributed to their initial risk of violent injury, greatly increasing their chances of violent reinjury, death, and involvement with the criminal justice system (McDavid, Cowell, & McDonald, A., 2011; Shibru et al, 2007). Risk factors associated with violent injury are largely influenced by the social determinants of health, and include poverty, drug and alcohol abuse, living with an abusive partner, lack of education, poor mental health, and historical experiences of community and structural violence (Dicker, 2016; Shibru et al, 2007; Snider et al, 2016;).

Trauma recidivism, defined as "new, recurrent injuries requiring evaluation and treatment" places a major burden on communities and health care systems (Chong et al., 2015; Noori, 2017, 847). Multiple studies suggest that experience of an initial injury, whether related to IPV or other forms of interpersonal violence, is a significant risk factor for subsequent reinjury, emergency room recidivism, and even death (Johnson et al, 2007; Hedges et al, 2005; Kuijpers, Van der Knapp, and Lodewijks, 2011; Snider et al, 2010; Noori, 2017). Some studies suggest that as many as 35% of victims of violence will experience a subsequent violent injury within a five-year period, and that as many as 20% will die as a result of violent reinjury (Smith et al, 2013). Violent injury recidivism is a public health problem that can be chronic and damaging to societies. However, research increasingly suggests that it is also preventable with the use of proper social interventions (Chong et al, 2015; Snider et al 2016). It is imperative that violence prevention interventions be integrated into delivery of emergency care for victims of violent injury and trauma (Snider et al., 2010; Zun, Downey, and Rosen, 2006).

Multiple HVIPs have emerged since the 1990s in order to address the psychosocial and socio-economic causes of interpersonal violence (Affinati et al, 2016; Smith et al, 2013; Chong et al, 2015; Dicker, 2016; others). Purtle et al., (2013) provide a succinct description of how HVIPs operate: "HVIPs combine brief in-hospital intervention with intensive

community-based case management and provide targeted services to high-risk populations to reduce risk factors for reinjury and retaliation while cultivating protective factors" (331). HVIPs have been widely acclaimed for their or applicability to various populations and social problems, such as smoking cessation, alcoholism, violent injury recidivism, intimate partner violence, HIV transmission, and others (Dicker, 2016; Fabiano, 1993; Prochaska, Wright, & Velicer, 2008). One reason for their success across various groups and social problems is that HVIPS include comprehensive and culturally sensitive case management that addresses the individual needs of service users. This gives the intervention model the high degree of fidelity necessary for exportation to various settings and situations, while allowing for the adaptability to tailor the program to the individual needs of service users (Smith et al, 2013). HVIPs have been shown to significantly reduce violent injury recidivism, as well as criminal justice recidivism (Chong et al., 2015; Shibru et al, 2007; Williams et al., 2005).

Emergency room admissions often represent a sobering moment in the lives of victims and their loved ones in which they are more apt to introspection, and more receptive to interventions such as HVIPs which target behavior change (Johnson et al., 2007). As admission into a hospital emergency room is often the sole point of contact between victims of interpersonal violence and the medical care system, practitioners often attempt to capitalize on this critical moment when patients and their families may be more likely to adopt changes to behaviors that may have put them at risk of violence (Affinati et al, 2016; Johnson et al., 2007; Kramer et al., 2017; Smith et al; 2013; Williams et al., 2005; Zun, Downey and Rosen, 2006). HVIPs begin in hospital emergency departments with what is known as the "teachable moment," or, "instances when individuals are particularly responsive to interventions, which promotes positive behavior change," (Dicker, 2016; Purtle et al, 2013, 332;). The teachable moment has been used as the theoretical basis of HVIPs and other interventions targeting behavioral change (Johnson et al 2007). HVIP service users are

then followed up by a case worker, sometimes referred to as a case manager for a period of time that is determined by the individual needs of the service user. The case worker provides emotional support, acts as a role model, and assists service users in overcoming any barriers that might be a hindrance to behavior change (Snider et al., 2016).

Experiences of violent injury do not only affect victims during their hospital stay, but may also often necessitate further medical treatment after hospital discharge, as well as impacting their abilities to resume work, caring for family members, and resuming normal daily activities (Leukhardt et al, 2010). While attempting to end IPV survivors often employ multiple safety actions and seek assistance from many community-based resources, such as domestic violence shelters, health care services, police, religious leaders, child care and social services (Bybee and Sullivan, 2002; Fugate et al., 2005). Sadly, many victims of IPV are unable or unaware of how to access these vital resources on their own. Because of this, case workers are an absolutely essential component to the success of an HVIP in promoting sustainable behavior change (Zun, Downey, and Rosen, 2006; Snider et al., 2010). In addition to their main role in HVIPs connecting service users to resources within the community, case workers are often members of the same, or similar communities as victims and thus, are able to establish trusting relationships and influence service users to avoid high-risk behaviors (Snider et al., 2016). The personalized treatment and support offered by case workers is especially relevant, because victims of violence come from various demographic backgrounds and will have specific challenges to sustaining change based on their individual experiences (Schrager et al., 2013).

While violence, and IPV specifically, are public health problems that affect victims from every culture and demographic background, certain risk factors such as poverty, substance abuse, and poor mental health can create extra complications for victims attempting to achieve sustainable lifestyle changes (Snider et al., 2016; Wortham, 2014).

Members of certain ethnic groups, other marginalized groups, and those in urban areas often face a disproportionate burden of violence and its associated adverse health outcomes (Dicker, 2016; Lipsky et al., 2006). In many studies of health disparities between ethnic groups, disparities are often treated as being based in biological differences rather than being socially determined (Krieger, 2014). However, Berkman and Kawachi (2000), employ the 'ecosocial' standpoint to help explain how experiences of discrimination can be embodied and expressed as physical health outcomes. They explain that experiences of racism, sexism, classism, etc., can be incorporated into the body and expressed biologically in ways that produce health disparities between dominant groups and those who are marginalized. Survivors of color, as well as survivors of the LGBTQ community often face additional barriers when attempting to access services, including health care, as doctors and other service providers often carry latent biases and prejudicial attitudes against survivors from marginalized groups (Bent-Goodley, 2007; Lipsky et al., 2006). Due to widespread heteronormative beliefs about who can be regarded as a victim, members of the LGBT community often have extra difficulties reporting IPV and receiving care. In some studies, gay men were found to be less likely to report IPV to the police because of cultural ideas that, as men, they should have been able to defend themselves. Further, in violent lesbian relationships, friends, family, and even domestic violence service providers were less likely to believe that the victim was in danger if the perpetrator had a feminine appearance (Anderson, 2005). Negative encounters with service providers can often lead victims from marginalized groups to distrust formal systems of care, and to avoid seeking treatment or legal support when they need it the most (Bent-Goodley, 2007; Lipsky et al., 2006). As we develop interventions for combating IPV it is important that we deepen our understandings of various socio-economic and cultural issues so that we can create interventions that will be effective for victims of diverse backgrounds. This also highlights the importance of the

culturally sensitive, personalized case-management provided by HVIPS, rather than a single universal model for aiding IPV victims in ending violence.

Building Resilience to Trauma

Resilience, defined by Kuijpers, Van der Knapp, and Lodewijks (2011, 199) as "the ability to successfully cope with, adapt to, and recover from major life stressors," is known to be a protective factor that can aid survivors and their children in avoiding the adverse health outcomes of IPV (Kuijpers, Van der Knapp, and Lodewijks, 2011; Wortham, 2014). Interventions that utilize resilience building strategies with victims and their families are incredibly important for ending the cycle of violence and preventing intergenerational transmission of the associated adverse effects (Wortham, 2014). Because abusive partners tend to alienate victims from friends and family, maintaining or regaining social support is especially critical for victims attempting to end their experiences of IPV (Bybee and Sullivan, 2002; Tan et al., 1995). Research has suggested that social support can help mitigate the adverse effects of IPV, that it can aid women in recovering after IPV, and that it may be a protective factor against future abuse (Bybee and Sullivan, 2002; Kuijpers, Van der Knapp, and Lodewijks, 2011; Tan et al., 1995). For people currently in abusive relationships, having supportive people in their lives can lead to increased knowledge and opportunities that can protect victims from IPV (Bybee and Sullivan, 2002). HVIPs help to improve the quality of victims lives by connecting them with community resources and social support necessary for building resilience (Bybee and Sullivan, 2002).

Description of the Intervention

There is much evidence to suggest that violence should be approached as a public health problem and that its consequences for society can be prevented (WHO, 2002). The

Navigator programme, a project that began within the Violence Reduction Unit (VRU) of Strathclyde Police in partnership with Medics Against Violence is a public health-based approach to violence reduction in Scotland. Specifically, the Navigator program is an HVIP that began in 2015 with a goal of facilitating people in moving away from violent or chaotic lifestyles. Like other HVIPs, the Navigator program approaches Emergency Department (ED) admissions as critical, or teachable moments when care workers not only have access to victims of violent injury, but those victims are also more likely to be open to receiving help in making positive behavioural change (Cooper, Eslinger, and Stolley, 2006). Participants in the Navigator programme are usually identified by medical staff in the ED as people who have had multiple admissions due to violent injury, and who may be open to accepting support. Medical staff are encouraged to refer such patients to the Navigator programme. The Navigators then follow up with participants in order to support them in a variety of ways necessary for participants to move away from violent lifestyles. This support often entails emotional support, role-modelling and mentorship, and connecting service users with partner organisations within the community for more specialised treatment and services. Other existing HVIPs have shown promising results in reducing both incarceration time and ED recidivism in the US and UK, however, they have mostly focused on youth affected by violence. The Navigators fill a unique role in that they support victims and their loved ones across the lifespan (Cooper, Eslinger, & Stolley, 2006; Goodall, Jameson, and Lowe, 2017).

Below is a simplified representation of the logic model of the Navigator intervention.

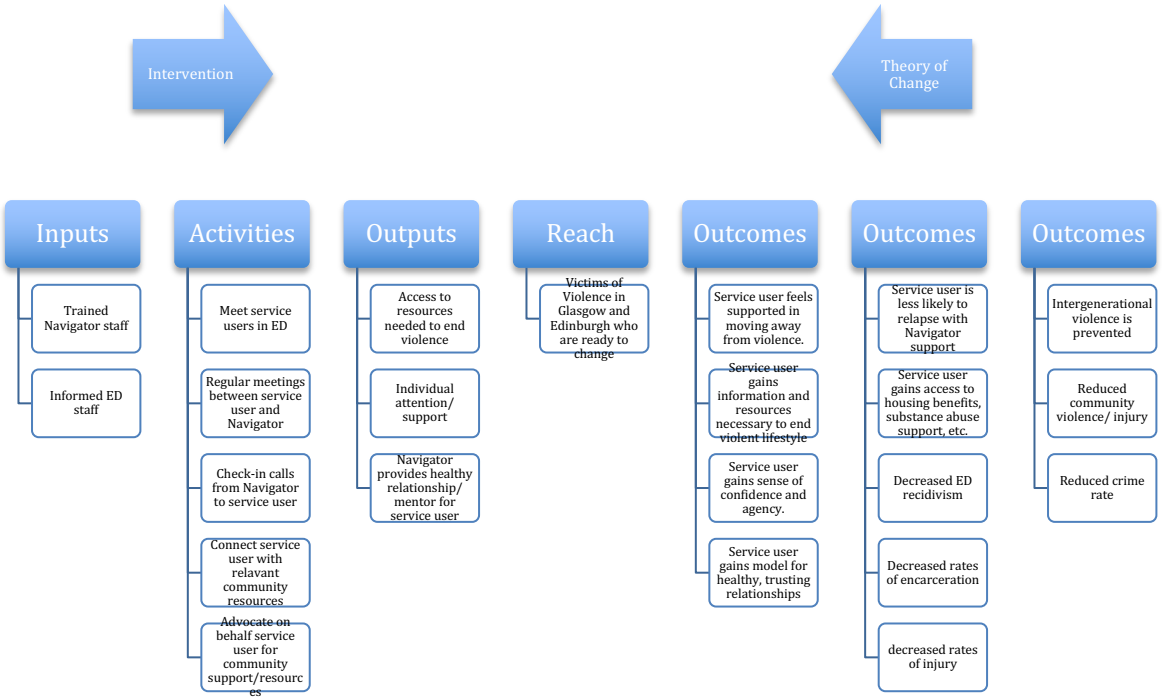


**Figure 1 Simplified representation of the logic model of Navigator intervention.**

**Taken from Young (2018)*

# Methodology

## Research Strategy

A qualitative approach using semi-structured interviews was used to collect data on the impact of the Navigator service from the perspectives of service users, partner organisations, and the Navigators. The goal of these interviews was to examine the experience of those who have engaged with the intervention, and to determine the effectiveness of the Navigator program in helping victims of IPV move away from violent lifestyles. A qualitative approach made it possible for this study to explore a greater depth of information from a small sample. A qualitative approach also allowed the researcher to explore concepts such as why people behave in certain ways, and what makes them change (Ambert et al., 1995).

Becker (1967) argues that it is impossible to do research that is not affected by the researcher's personal values and perspectives. He argued that the goal of the sociologist is often to express the point of view of those who are being studied, and in so doing, the sociologist lends credibility to their subject (Becker, 1967; Bryman, 2016). The approach to data collection used here was largely informed by Standpoint theory, a feminist research method that argues that knowledge comes from one's position in society, and that, especially members of marginalized groups have access to specific knowledge that is not available to those in more privileged social positions (Borland, 2018). Standpoint theory emphasizes that all knowledge is produced and shaped by our subjective experiences, and that in societies with embedded social hierarchies, such as those based on race, class, patriarchy, heteronormativity, etc., one's social position determines what they can know. As such, when members of marginalized groups are excluded from public discourse, so too is the knowledge that they alone can produce (Borland, 2018; Hill Collins, 2009). Thus, the standpoint of members of marginalized groups is a much better starting point for researchers to begin inquiries (Borland, 2018; Smith, 2012). Feminist standpoint theory is particularly relevant to

this study because of the frequency with which victims of IPV of all genders and sexual orientations are shamed, silenced, and alienated in various ways throughout society (Garcia, 2004). In this regard, only those who have experienced the Navigator service are truly qualified to evaluate if and how this intervention helps victims of IPV.

Employing a semi-structured interview strategy facilitated data gathering that was centered around the perspectives of interviewees, as opposed to a more structured style of interviewing, which would have reflected the perspective of the researcher (Bryman, 2016). The use of semi-structured interviews also made it possible to gain information about how the intervention is experienced by service users and delivered by Navigators that will be much more nuanced and informative than is possible to gather with other methods, such as surveys, which necessarily limit the potential responses of study participants. Utilising an interview-based approach to this study ensured that the voices of the participants were heard above all else.

Although the interviews were relatively brief, taking between 20 and 40 minutes to complete, the interview questions were designed to encourage open discussion about participants' experiences of the Navigator service. The use of open-ended questions allowed gathering of the desired information about the Navigator service, while also uncovering several interesting and unexpected themes for future research.

## Ethical Considerations

Ethical approval was obtained from the University of Glasgow School of Social and Political Sciences board of ethics. The ethics application was submitted under the category of "high risk" due to the participants' common experience of IPV, and the potential for some participants to mention any details of abuse. There was also some concern from the ethics

board that former partners of victims of IPV may try to identify the participants once this study became publicly available. The participant information sheets were amended to include the possibility that someone could potentially attempt to deduce who had participants of this study were, but that their identities would never be given away by the research team. Participants were also made aware of the ways this study would be used, including potential publications in academic journals, presentations at conferences, and as part of the requirements for a master's degree. Some of the other ethical considerations to be included in the application were as follows: Approval of the proposed interview questions; recruitment of participants through the Navigator service; the use of telephone interviews to gather data; the proposed participant information sheet detailing, in plain language, the purpose of the study; the secure storage of data and some personal information, such as first names of the participants; the recording of all interviews; and the publication of select participant information with appropriate annonymisation.

Sampling and Recruitment

This study utilized a purposive sampling strategy, meaning that participants were chosen, not at random, but because they had been involved with the Navigator service in one of the three aforementioned capacities (Bryman, 2016). The criteria for sample selection included being a Navigator who had worked with victims of IPV, a member of a partner organisation who had worked with a Navigator to support victims of IPV, or a person who had used the Navigator service due to either a first-hand experience of IPV, or because they been closely involved in supporting someone who had experienced IPV. The Navigators were recruited by the program coordinator, while service users and members of partner organisations were recruited through word of mouth by the Navigators with whom they had worked. Participants were informed about the research by their Navigator support worker and

asked if they wished to take part in the study. There were six participants in total. The sample size was limited because of both time constraints, and the small number of people who fit the criteria for this study. However, despite the small number of participants, nearly complete data saturation was reached, and the number of participants was sufficient for generating theory (Pope, Ziebland, and May, 2000).

Three of the four Navigators working in Scotland were the first to be interviewed, the fourth Navigator had recently joined the service and so was not asked to take part as their experience was very limited. Although it was made clear to the Navigators that no questions relating to violence or personal traumatic experiences would be asked of their service users, the Navigators were reluctant to recruit their own clients for participation in this study. One Navigator stated that she wasn't sure any of the clients she had worked with "would be in a good enough place," to participate in interviews. In this way the Navigators acted as gatekeepers who were, perhaps, concerned about protecting their clients from potential distress (Bryman, 2016). The Navigators were much more willing to recruit other professionals in the field from partner organizations with whom they had collaborated to create clients' treatment plans.

Participation was voluntary and no incentives were offered. Each person who agreed to take part was also given a participant information sheet about the study so that they were aware of the research aims before the interviews began. To ensure that this study minimised any potential distress to participants, questions asked during the interview focused exclusively on participants' experience of the Navigator service, and their ideas about behaviour and lifestyle change, rather than any experiences of trauma that may have led participants to the Navigator service. Participants were also made aware that they could refuse to answer any questions, and that they could end the interview at any time. Interviews did not begin until informed consent is obtained verbally with the use of a standardised

consent form. This was recorded prior to the interview beginning. Participants were also informed that their confidentiality would not be guaranteed if they disclosed any criminal activities that the researcher would be ethically required to report to police or other authorities. If at any point during the interview a participant had become distressed, referrals to appropriate support services would have been provided, and the research supervisor would have been notified. While participants had no trouble finding a secure location in which they felt comfortable giving the interview, they were made aware that they could cancel or postpone the interviews if they could not find a suitable location, or for any other reason.

Interviews

Six semi-structured interviews were conducted between August and September 2018 in Glasgow, Scotland, though participants were residents of both Glasgow and Edinburgh. The respondents included the mothers of two Navigator service users who had previously experienced IPV, as well as three Navigators (service providers), and one member of a partner organization who has worked with Navigators to provide support to service users who have experienced IPV. Participants were interviewed individually via telephone, as this eliminated the need for participants to travel and made the process more inclusive for all of those involved. Due to the nature of telephone interviews, they could be carried out in any location where the participant felt comfortable and secure, and it allowed them to maintain a further degree of anonymity. This may have encouraged participants to be more honest and thorough in their responses. Data could also be collected more quickly with the use of telephone interviews, and the safety of the researcher could be assured, as neither travel nor face-to-face interaction were required (Braun and Clarke, 2006). The interviews were recorded and professionally transcribed for further analysis.

Three separate interview schedules were used to reflect the different perspectives of the respondent groups (Navigators, partner organizations, and family members of service users). Having three groups of respondents with three different interview schedules allowed the triangulation of their responses, meaning that the perspectives of multiple observers could be studied to explore if and how the Navigator programme helps victims of IPV (Bryman, 2016; Denzin, 2012). Triangulation is useful for several reasons, one of which is that the incorporation of multiple perspectives, or "accounts of social reality," into the research lends the study added credibility, richness, and depth (Bryman, 2016, 390; Denzin, 2012). The questions included in the interview schedule were created in collaboration with the Navigator programme coordinator, a key stakeholder, and reflected, in part what she wanted to know about how the Navigator service was operating. Topics included: what service users' lives were like before the intervention, what about the intervention helped them change, what worked well about the service, what could be improved about the service, how Navigators coordinated with outside partner organizations to create or supplement service users treatment plans, how Navigators work with victims of IPV differs from that with victims of other types of violence, whether certain groups of service users required specialised care, and how services users felt about the support they received from the Navigators.

Data Analysis

Framework analysis was used to uncover themes and patterns in the data. This choice was made because of the applied nature of this research project, and because the goal of this investigation, to find out how the Navigator program helps victims of IPV move away from violence, was predetermined at the outset of this study (Gale et al., 2013; Pope, Ziebland, and Mays, 2000). Five stages of framework analysis were employed: familiarisation with the data; identification of major concepts and themes; indexing and charting the data; and

mapping and interpretation, where the themes that emerged from the data were linked and explained (Pope, Ziebland, and Mays, 2000).

The data was coded manually. Transcripts and notes from the interviews were read in detail and a table outlining the interview questions and responses from all of the participants was created. Key concepts and phrases that were theoretically relevant to the research questions or consistent with or contrary to the findings of previous literature were identified and labelled. This allowed identification of patterns and connections within and between the three groups of data. Although the interviews were relatively brief, the data that was gathered was rich in detail and allowed for the identification of multiple themes and categories.

# Findings and Analysis

During this study a number of themes and patterns emerged that demonstrate the experiences and perceptions of the study's participants. The goal of this study was to develop a deeper understanding of how the Navigators work to support victims of IPV in Scotland. In order to accomplish this the study relied, not on statistics or crime reports, but upon the perspectives of those who have experienced the Navigator service directly. Included here is a discussion of the key findings from interviews with three groups of people affected by the Navigator service: The Navigators themselves, a member of a partner organization who specialises in supporting victims of IPV, and the mother's of two young women who have worked with the Navigators after experiences of IPV. The young women themselves were not available for interviews. However, as the Navigator service provides support to family members and caretakers of victims of violence, the mothers of these women are Navigator service users in their own right. The narrative expressed in this section was delivered as much as possible in the voices of those who were interviewed. Thus, somewhat lengthy quotations have been included here, rather than paraphrases of the words and experiences of this study's participants. All of the quotations included here are necessary to understand the perspectives of those who have engaged with the Navigator programme.

**Figure 2**

*Themes and subthemes found in responses.*

| Major Themes | Findings |
|---|---|
| Who Are The Navigators | *Local caseworkers, meet service users in A&E, connect service users with services in the community, provide practical and emotional support to service users* |
| Supporting Victims of IPV | *Victims of IPV require more specialised knowledge and care than victims of other types of violence.* |
| Working With Outside Partner Organisations | *Navigators prioritise building relationships with existing service organisations within the community to which they can refer clients for specialised care.* |
| What Works Well about the Navigator Service? | *Offering judgement-free, inclusive, holistic approach to any victims of IPV.* |
| Supporting Loved Ones of Victims of IPV | *Families of victims are also affected by trauma. For the mothers of victims of IPV, Navigator was the first service to offer them support.* |
| Building Resilience Through Social Support | *Victims and their families felt more confident and had higher self-esteem after the Navigator service.* |
| Supporting Male Victims of IPV | *Social norms related to masculinity are major barriers to help-seeking behaviours among men, and case workers abilities to support male victims of IPV.* |
| What Makes People Change? | *All respondents stated that human connection is what helps people change.* |
| The Teachable Moment | *Meeting service users in A&E was extremely important because victims of violence are more likely to accept help* |
| No Strings Attached | *Service users are not pressured to take part in the intervention.* |
| Demand For More Navigators | *All respondents felt that more Navigators would make the service more effective.* |

## Who Are the Navigators?

Although it has been described elsewhere in this paper how the Navigators, and HVIPs in general, operate, it is important to hear from the Navigators themselves what they do and how they perceive their roles in supporting victims of IPV and other forms of violence. Thus, interviews with each of the Navigators began with the question, "Can you tell me a little about what you do as a Navigator?"

> *As a Navigator, we are a violence intervention service. We work with those patients who are, um, attending A&E departments, or accident and emergency departments at some of the hospitals in Scotland, and who have injuries in connection with a violent, chaotic lifestyle. And we use that moment when they're contemplative, um, in the hospital setting to have a conversation with them. So, I find out and establish what's been going on in their life that's bringing them into contact with the violence, and usually those recurring themes of homelessness, addiction, mental health, social isolation, family breakdowns, gang-related stuff, and a whole multitude of other issues we look to try and stabilise them for people. We aren't necessarily interested in the incident that's caused the injury. We want to look at the precursors to that. We want to work out what in their lifestyles, what's happening in their life that's potentially bringing them into contact. And from there, we suggest ideas for working with services in the local community, um, and by bringing that all together we try to give them their options to sort of lead the life [unclear]. Ideally, we could help navigate them towards leading a healthier life*. –S (Navigator)

The other two Navigators interviewed gave extremely similar responses to the one S provided. However, one of the responses also specifically spoke to one of the major goals of HVIPs, which is preventing emergency department recidivism due to violent injuries, which is echoed throughout much of the literature about HVIPS (Snider et al., 2010).

> *We try and offer them support, and prevent them from reattending into the hospital with similar injuries*. –T (Navigator)

In order to better understand what draws a person to such a specialized position that requires so much time and emotional investment, each of the Navigators were asked, "How did you become involved in the Navigator service?" They each stated that the Navigator position had been advertised and that they had applied to the position the same way they would have

applied to any other job. They also expressed that it was because of their own previous experiences that they were attracted to the role of Navigator. Each of the Navigators had had extensive experience working to support people who were struggling with various social issues before they became aware of this intervention. When asked what had made her believe she would be a good fit for the role, one Navigator explained:

> *Um, just because of the job that I was doing at that point in time. I was working with um, women and children affected by domestic abuse. I was responsible for their housing and homelessness needs. So I [unclear] adult side of the support package. And my previous history of working in sort of young people's homeless organisations. Um, it was kind of bringing together all of the experience and expertise that I'd gathered over the years and it brought it under one umbrella. So it meant that I was putting together a whole lot of things that I had a passion about, and that I know.* –S (Navigator)

Another Navigator explained how he had discovered his passion for making a difference in the lives of those affected by violence after coming from a very different career trajectory:

> *Er, so I, I started working for Navigator back in 2015. Er, it was myself and another guy who were the sort of, first navigators. But I became involved in the Violence Reduction Unit back in 2014, when I was still in the military, and, er, the Violence Reduction Unit had asked the, the company that, er, of the military I was working for, if they would help support them at the Commonwealth Games, as a, a, a mentor for some of the individuals that were gonna be taking part, er, their cohorts that were taking part. And I really enjoyed the work. I really, um, found a, a great sort of, satisfaction, working with the Commonwealth Games program. And er, yeah, I was eager to get involved, eager to do more. I could see that it was, er, really impactful work, and it was worthwhile, and it was, er, changing people's lives, and that. I really wanted to be a part of that.* –T (Navigator)

Also of interest was how the Navigators were perceived by members of the partner organizations who worked with them. A, a member of a partner organization that specializes in helping victims of IPV said of her first impressions of the Navigators:

> *It was a pleasure to speak to them because I thought it was a great thing to be happening within the A&E when that's a very good time to actually be able to contact, uh, victims and speak to them on their own. You know, it's a real opportunity*

> *that had been missed in the past and definitely forward thinking as far as that's concerned*. –A (Partner organisation)

One of the Navigators interviewed, G emphasised the point that the Navigators, in addition to being caring individuals who are motivated to help people who are affected by violence, are all highly trained in issues surrounding IPV, and the general social factors that contribute to the cycle of violence:

> *You know, two of the Navigators are both, um, myself and [other Navigator] are specialists in domestic abuse, which is a, it's an amazing skill to have because as far as I'm aware, it doesn't happen anywhere else in Scotland.* –G (Navigator).

What Is Different About Supporting Those Who Have Experienced IPV?

Each of the Navigators emphasised that, while they approached each victim of violence with whom they worked as an individual who would have unique needs in terms of treatment plans, there are some specific considerations to take into account when dealing with violence caused by an intimate partner.

> *Yeah, I mean, [sighs] I don't think you can treat any particular issue the same. Everybody's er, a, sort of, unique individual, and they treat things differently. So, but when it comes to interpersonal relationships, I think there's, there's a sort of wider level of compassion and understanding that needs to come to [unclear] that particularly, er, difficult situation. Um, because there's more than, sort of, one person involved at any given time, as well*. –T (Navigator)

While all of the Navigators interviewed emphasized that each client must be supported based on their individual needs, they also acknowledged the importance of understanding that because of the extremely personal nature of IPV, it often requires even more sensitivity than other forms of violence:

> *There are certain things that you can advise to every person that's affected by violence. But, when it comes to domestic abuse it tends to be about more complicated things in the sense that we don't know if the person perhaps is returning to the relationship, if the perpetrator maybe, has been looking for them, if we need to get them to a safe place. So there is a lot more risk involved in managing something*

> *that's affected by domestic abuse, just because of the nature of the relationship. Both myself and [other Navigator], we've got specialised training which allows us to respond to victims of domestic abuse in a very specialised way* –S (Navigator)

Working With Outside Partner Organisations

One of the main goals of the Navigator programme is to maximise the sustainability of the intervention by partnering with social care services that already exist in the community. Rather than attempting to address all of the of the personal and social factors that lead to, and perpetuate violence in their clients' lives, one of the aims of Navigator service is to act as more of bridge and a guide to existing services after identifying which ones would be most helpful to the client. This section explores how the Navigators work with outside partner organisations. One of the Navigators interviewed succinctly described the specific role that the Navigators attempt to fill and why it is necessary to incorporate the work of partner organisations into clients' treatment plans:

> *I think because there's only two of us based in each hospital, then it is imperative that we've got good links with services that are out in the community. Um, the level of violence that we see in the hospitals, it would be impossible for two people to provide a good service to all of those people. Um, I think people need longer-term work sometimes, and there needs to be the relationships built up so that we can refer them to more specialist services that can support them long-term. I think those services, they're already in the community, so it wouldn't make much sense for us to be inventing them here*. –G (Navigator)

Recognising the importance of inter-agency collaboration is a key feature of the success of the Navigators. However, the ability of the Navigators to establish themselves in the community has not only been beneficial for their work with partner organisations to support victims of violence, but it may have also had the affect of building victims' confidence in the ability of community-based institutions to provide that support:

> *The agencies that we tend to use, um, most regularly are the police and ASSIST. So, the police have a domestic abuse unit and ASSIST are the specialists in domestic abuse advocacy and support agency. We have an agreement with the police so that we can get a domestic abuse team to speak to a victim of domestic abuse, without them having to report at that time. And just allow us to build a relationship and allow the person to get confidence about what the police can or cannot do. We find that quite successful and a lot of our patients have went on to report their experiences of domestic abuse*. –S (Navigator)

It is significant that S specified that the Navigators' agreement with the police includes the condition that victims are not pressured to report their abuse in exchange for support. Not only does this ensure that the victim's agency is respected, but it can be critical for building trust between victims of violence and those they turn to for help. If HVIPs in general, and the Navigator programme, specifically, are able to help build trust between community members and social institutions, such as the police and health-related services, this could extremely beneficial to the long-term health of communities, as many people affected by violence are also members of marginalised groups who may be reluctant to engage with social institutions after having had negative experiences with them.

## What Works Well About the Navigator Service?

One of the goals of this study was to find out what works well about the Navigator service from the perspectives of those who engage with the service in various ways. This section I explores the major successes of the Navigator programme as described by service users, partner organisations, and the Navigators.

### Supporting Loved Ones Of Those Affected By IPV

One of the common themes echoed by both of the parents of victims of IPV interviewed in this study was that the Navigator service was the only one to acknowledge family member's needs for support while caring for victims of IPV. Both of the mothers of

service users interviewed for this study had been heavily involved in their daughters' recovery and care after experiencing IPV, an undertaking that, for many would seem heart breaking and overwhelming. While many services focus on supporting only the individual who has directly experienced IPV, the Navigator programme recognises that those closest to victims of IVP also require support.

> *It was the first time someone had offered support to me as a parent.* —L

Another theme that emerged several times throughout the interviews with both of the mothers of service users was that their roles as parents actually limited their abilities to help their daughters process their respective traumas and recover from them. In addition to the direct support Navigators gave to these parents in the forms of advice, or simply listening, both of the parents of service users found it immensely helpful to have another adult invest so much in their child's recovery and wellbeing. Both mothers emphasized repeatedly that the Navigator had been the first adult who was not a parent to offer support to their daughters through their struggles, and that this had been invaluable to their daughters' progress:

> *To have another adult who wasn't her mum telling her that it wasn't her fault, and that she can get through it made all the difference… she now understands that it wasn't her fault… A parent couldn't do this by themself*. –P (Mother of service user)

L also stressed that the fact that G had had similar traumatic experiences to L's daughter lended her added credibility and made her daughter more likely to accept G's advice and support.

> *There's nay better person to speak to than somebody who's been through something, um, and I think that's the key part with G and [daughter], is having someone who really understands, um and actually seeing how G has moved on and persisted in life. I think she's an inspiration to [daughter] in that way*. –L (Mother of service user)

Building Resilience Through Social Support

The victims of IPV whose mothers were interviewed were both very young women. At the time of this study they were aged 21 and 17, respectively. The elder of the two survivors had been to the Emergency Department between six and seven times prior to meeting the Navigators. When the mother of the eldest survivor was asked, "What was your daughter's life like before she met the Navigators?" she explained that before meeting the Navigator, G, her daughter had blamed herself for past experiences of sexual assault and IPV. She had chronically suppressed the traumatic experiences she had gone through, and had been unable to confront, or emotionally process them. As a result, she had had problems with drug misuse and self-harm. L said of her daughter:

> *Um, she blamed herself for a lot of things that had happened in the past with abusive relationships and sexual assault. I mean, even though she was hearing through mum and dad that it wasn't her fault, she's not had the support, the nurses telling her, or any sort of support than, other than this, angel, I can only call G, who really is saying all the things that mum and dad said to her all along, but it's different because it was mum and dad. But then this G, who she's never met before, is telling her all the things and reassured her that it's not her fault, she gave my daughter some hope, and maybe it made her see that this isn't her fault, and I understand, and the way she's feeling isn't abnormal, and lots of people that go through this feel the same as her.* –L

To gain a deeper understanding of the impact of the Navigator service on peoples' lives, L was asked, "What, if anything, has anything changed in your daughter's life since meeting G?" She stated that her daughter had more self-esteem now, that she is now better able to process her emotions, and that she understands now that she *is* capable of getting through hard times:

> *Her attitude, um, has changed on how she feels about herself. She realises what she's been through now isn't just something to be brushed under the carpet. She's always tired, before she met G, to just brush things under the carpet and never understood*

> *why things made her so upset, and why she couldn't just get over these things, and that's why she just kept on relapsing with self-harm or things like that*. –L

Based on the definition of resilience used in this study as "the ability to successfully cope with, adapt to, and recover from major life stressors," it is clear that having the support of the Navigators during this time of crisis played a major role in aiding these families in building resilience so that they could successfully manage their respective traumas (Kuijpers, Van der Knapp, and Lodewijks, 2011, 199):

> *Now, since G's been here, and been involved with her, she realises that she has to deal with these issues, and for the first time in so many years, she's actually facing up to what she's been through, and she realises that it is a big thing that she's been through, and she didn't deserve to go through it. Um, and seeing herself for the first time, how we all feel, that… I think she's, that's what she's got out of G. And I think she's validated a lot of things that [daughter] feels, that it's ok to feel like that and with her support and family support, she will get through it*. –L (Mother of service user)

Also interviewed was P, whose now 17 year old daughter had a slightly different experience. It was P's daughter's first time being admitted to A&E and her first time experience of IPV. When asked, "What was your daughter's life like before she met the Navigators?" P responded that her daughter had "had a normal life," and was "just like any other teenage kid with issues." She said that before "the attack," her daughter had been "much more naïve and trusting," of all kinds of people.

When P was asked, "What, if anything, has anything changed in her life since meeting Navigator?" she responded that her daughter was "much more aware of her surroundings now," and that "she's much more aware of what the world can be like." P also mentioned some more positive changes in her daughter: "She understands now that she can't control the actions of other people," but she can control how she responds. Both of these young women benefitted greatly from having the support of an adult who was not a family member being

willing to take the time to really listen to their stories and validate their feelings and experiences:

> *She has a lot more confidence in herself and knows that she can get through difficult situations.* –P (Mother of service user)

Supporting Male Victims of IPV

Many services that support victims of IPV, including several organizations in Scotland, exclusively offer support to those who identify as women or gender non-binary persons (Ard and Makadon, 2011). As a result, men and other people affected by IPV can find it difficult to find services in their communities that are willing to support them. The Navigators are special, if not unique, in that they offer support to any person affected by IPV, or violence in general, regardless of gender identity or sexual preferences. Each of the Navigators were asked if they had personally supported victims of IPV who were not women who were partnered with men:

> *Yeah, so, we've worked with men, er, women, er, transgender, you know, the LGBT community. It's, predominantly, you know, men's violence against women, but we have worked with, er, multiple genders, and [audio is interrupted] who have experienced domestic abuse.* –T (Navigator)

It was important to discover if, as has been found in previous literature, there were any differences in the support that was needed by service users who were not straight women. All of the Navigators pointed out that men often had the most trouble discussing IPV and seeking treatment:

> *I would say, there's one thing that's really different is, well, nobody really wants to admit that that's what's going on, but we've found in men, especially, there's a sort of avid resistance to opening up and talking about that. So, I think there is a, you know, like a male pride, it's a bit of a barrier that guys chuck up, because I think they feel like it's embarrassing. Although it's embarrassing, or hurtful, or shameful for*

> *anybody, but I think it's just getting the men to feel comfortable enough to open up and talk*. –T (Navigator).

One of the major themes identified in conversations with the Navigators was that men who have experienced IPV are often less receptive to receiving support or treatment, and often find it more difficult to discuss their experiences. Each of the Navigators indicated that when working with male victims of IPV, regardless of whether the violent partner was a man or a woman, perceptions related to masculinity and shame associated with victims' inability to defend themselves were major barriers to supporting male victims of IPV. S described the particular complications she encountered while working with young men who had experienced IPV:

> *We've had youths that have been abused by their female partners. Um, so usually, in my experience, it's a lot more difficult to get them to open up because of issues of masculinity. They're embarrassed by the fact that, especially if it's a female on male dynamic, um they're embarrassed by the fact that a woman attacked them. So, they find that a bit of a barrier for them to report going forward.* –S (Navigator)

In addition to the complications presented by the construct of masculinity, two of the three Navigators who were interviewed stated that one of the barriers they encountered when helping men was the reduced number of services that support men experiencing IPV. The Navigators had fewer partner organisations with which to connect male victims. The lack of support available to men from the community seemed to potentially add to the sense of shame and alienation male victims felt while recovering from IPV. This was consistent with the findings of previous literature (Ard and Makadon, 2011).

> *Because services are designed around a response to women, and there is a lot more support available to them. Um, and I think that men struggle to ask for support, initially anyway. Um, so I think that's a barrier for them [unclear] for the support. I think they often feel they should be able to manage it themselves and quite often, they can't*. –S (Navigator)

## What Makes People Change?

The major questions that the creators of the Navigator programme seek to answer are "What makes people change?" and "How best can we use that to stop the cycles of violence in people's lives?" Attempting to end the cycles of violence in peoples' lives through behavioural change is a complicated endeavour. As one Navigator explained:

> *I mean, the biggest barrier we come across for anybody is, is just, sometimes people aren't ready, because it's, you know… People normalise these particular lifestyles to the point where it's, on a day-to-day basis, it's become like a normal way of living for them*. –T (Navigator)

A number of themes emerged around the question of what makes people change, including the importance of the teachable moment, and the importance of meeting people, face-to-face, in the hospital setting. However, overwhelmingly, the Navigators maintained that the causal mechanism of the Navigator programme that helps people change is developing a personal relationship with their clients. The relationship is facilitated by the context of teachable moment, in which victims of violence are at their most vulnerable.

When asked, "Was there anything about the Navigator service that worked well for your daughter?" L quickly responded:

> *The fact of G personally being there, and that the she came to us when we were scared and vulnerable, and we didn't have to reach out to anyone for help- we didn't know where to turn, and they were just automatically there*. —L (Mother of service user)

One Navigator succinctly explained why this moment can be so powerful for building trust between victims of violence and Navigators:

> *We've not run away from them in their worst moment, when they're in the hospital*.–S

Meeting an empathetic and knowledgeable person who offers support, rather than judging or rejecting them, at such a critical time seems to make victims of violence more apt to trust someone such as a Navigator.

"Catching the Person at the Right Time" and the Teachable Moment

Almost every participant interviewed in this study alluded to the concept of the "teachable moment" as being extremely important to the Navigators' ability to reach people in a way that would help them make sustainable change. Parents of service users, members of partner organisations, and Navigators alike all emphasised that it was when victims of IPV were in the A&E due to their injuries that they felt most afraid and vulnerable, and were most receptive to information about how they could begin to change their lives:

> *Er, well, I think a, sort of, key stand-out point is the, um, ability to have a conversation with somebody in the hospital, um, you know, after an assault or attack. I think that that's key to our service, is being there, um, at a time where people are… I mean, the emotions and the reality of it is raw. Um, and that's when people are most likely to want to talk about it, because it's fresh, and… You know, in the hospital as well, there's no denying the reality that, you know, an individual's lifestyle has left them being in the emergency department. So, these are all gateway opportunities we have to really support somebody*. –T (Navigator)

Because of the hidden nature of IPV, it can be difficult for victims who may want support to seek out and access services. In addition to all of the physical barriers to seeking assistance, many victims of IPV simply do not know what services are available to them, or may be too consumed with the trauma they've just endured to even consider reaching out to a support service. However, because the Navigators are based in the hospital, they have a unique point of access from which to identify those suffering from violent injuries, and to take the burden of finding support away from victims by coming directly to them.

> *Our work is passed to us from the police. We can accept referrals (from other support agencies) as well. Whereas the Navigators is very much based in the hospital and that's where they get their work from, and it's a very positive move because it's*

> *another way of engaging the clients we wouldn't normally have contact with and not be able to support them in the same way.* –A (partner organization)

Respondents also emphasized on multiple occasions that the hospital setting itself was key to the impact of the teachable moment. When A, a member of a partner organization, was asked what she thought worked well about the Navigator service:

> *Oh, gosh. I think catching a person at the right time. And obviously when they're in the hospital and they're able to be seen on their own, because at that time I think they would be in a high state of fear and anxiety, and I think a Navigator would be able to calm that down a bit, and be able to inform them of what they're able to do to protect them and move things on, or do whatever [she] wants.* –A (partner organisation)

A pointed out that the hospital setting provides a safe space for victims of IPV to disclose their abuse and to gain access to information about the resources available to them. One of the Navigators, T, also emphasised the importance of the hospital setting, stating that it gave the Navigators the necessary time to fully understand a client's needs and give appropriate information and advice:

> *They're in there to be seen by a doctor or a nurse. There's a good chance they're going to be in there for a few hours, um, and that's a few hours' opportunity that we have to really get an understanding of what that person's situation's like, and give them a good understanding of the particular resources we have access to for both, sorry*, all *genders*. –T (Navigator)

Even more important than the experience of providing the Navigator service within the hospital setting is how service users feel about the Navigators being in the hospital. When asked what she thought worked well about the Navigator service, one service user responded:

> *I think it's good that the service happens in the A&E, when you're confused and overwhelmed, having someone instantly be there for you was so important*. –P (Mother of service user).

P and L both repeatedly expressed gratitude for the Navigators, who sought them out and anticipated their needs for instant, non-judgemental support during an extremely stressful and confusing time in their lives.

No Strings Attached

It may be worth mentioning that gangs, religious sects, and others use techniques similar to the teachable moment by offering support and gratifying interpersonal relationships to people who are emotionally, physically, or economically vulnerable in order to recruit them to a specific cause and to further an agenda (Blazak, 2001, Stark 1980). Thus, there is much evidence that people who find themselves in particularly vulnerable circumstances are especially susceptible to behavioural change. What can be seen as manipulation of this sort generally brings with it a negative connotation. However, the difference in the use of the teachable moment in the context of HVIPs is not only that the benefits of the behavioural changes extend to both the recruited individual and to the society in which they live, but much more importantly, it is that the individual is not coerced in any way to take part in the Navigator Programme. Navigators offer support to the their clients without demanding any measure of compliance or even progress on the part of the victims they serve.

> *So, the most, sort of, difficult part about that is, is trying to, to get people aware that there is support out there, and sometimes you end up wanting it more than they do, at times. So, it's really just utilising the conversational side you have with them, and making them aware that, you know, the support is available when they're ready, you know, change can happen when they're ready.* –T (Navigator)

The point T made about service users not always being ready to change was echoed in my interview with A, a member of a partner organisation and specialist in IPV who works with the Navigators:

> *I mean, sometimes they want to stay with their partners anyway. But they can see where it's [the Navigator service] providing options and talk about what's happening until they recognize it's domestic abuse. You know, it provides a great opportunity*. –A (Partner organisation)

Another Navigator, S also emphasised that a crucial element of what makes the Navigators successful is their respect for the abilities of the people they serve to make their own choices regarding their treatment plans and lifestyles:

> *I think because we're not a pressurised service, so that… I don't think we put pressure on people to do anything. I think the reason that is works is because we speak to then, and we're kind, and we're empathetic and we're non-judgemental. And I think because we're not a service that… you know, we must achieve this by two weeks, or three weeks… They're in control of their support.* –S (Navigator).

The Navigators, as well as A, all emphasised that respecting the agency of their clients was critical to the ethos of the Navigator programme, and to what makes the programme successful:

> *It's about finding the safest possible way to manage their situation. So, um, empower them, because we don't want them to feel that they're to blame, for them to feel guilty, of the other emotions that would be really quite detrimental to their situation. They might not be ready to leave at that point, but what we can do is advise them of the services that they might not be aware are available to them as an option. And we'll always ask them if it's ok for us to call, and if not, we'll get them out number, if it's ok for them to take*. –S (Navigator)

## Demand For More Navigators

The last major theme identified in interviews with the Navigators was that they felt the program would be more effective, and better able to reach a greater number of those in need, if they had more funding with which to hire like-minded, properly trained, and compassionate Navigators. Although, one of the Navigators, S, was adamant that only a certain type of person could become a successful Navigator, and that certain personal

qualities essential to the role could not be trained. When asked what, in her opinion makes a good Navigator, S replied:

> *I think somebody who's had some sort of personal experience in their life, whether that's wholly negative, or a combination of negative and positive stuff. I think to find somebody that's kind, serious, not judgemental, um, and goes above and beyond, basically, you know, uh, Navigators are all going to work more than they're required, you know, to get involved with somebody. They want to do everything that's possible to try to help them. You can teach people about the services and stuff like that, but you can't instruct them how to be kind. You can't teach them how to be empathetic. And I think that's a big part of what makes Navigators special*. –S (Navigator)

The sentiment that having more Navigators would be the best way to improve the service was echoed across the board by all respondents:

> *Um, the only thing I could see that would be an improvement, um, is probably just quantity, to have more of us, more coverage in the hospital. The hospital… you never know who's going to tip up with what kind of injury. You never know who's struggling with what until they end up in hospital. So with two Navigators per site at the moment, I think being able to offer, um, a sort of wider service in the hospital would be fantastic*. –T (Navigator).

When asked how the Navigator Programme could be improved, both of the mothers of service users emphatically stated, "More of them!" P quickly added that she didn't say that because the current Navigators were not doing a good job, but because she could tell that they were always quite busy, or "stretched." She also added that the Navigator who had helped her and her daughter had gone above and beyond what could be expected of a support worker, helping her daughter find counselling and youth drop-in services which provided a safe space for young people to socialize, and simply being available to both mother and daughter any time they needed advice or someone to talk to.

> *My daughter has said that she doesn't even know how she managed to open up and start saying where all her trauma has come from, and she said if… My daughter is training to be a nurse, and she said, if she could ever make somebody feel the way G made her feel, so special and so safe, then she would be delighted if she could offer that to somebody*. –L (Mother of service user)

# Discussion

Despite the small scale of this study, the themes that emerged from it have illuminated a number of interesting points for future research to explore.

Overwhelmingly, the Navigators maintained that it was the human interactions they have, and the relationships they build with service users that allow them to effectively help victims of violence recover from trauma and change their lifestyles. Similarly, the mothers of victims of IPV who were interviewed maintained that the interactions the Navigators had with their daughters, as well as themselves, were critical to building self-esteem and confidence in their abilities to get through difficult or even traumatic experiences in the future. To date, limited research has thoroughly explored the role of interpersonal relationships in building resilience. Scholars of trauma studies should continue this work, as resilience is a critically important trait for the health of those who experience trauma.

Another finding which could be of interest to scholars of trauma studies was that the mothers of Navigator service users interviewed here felt that they were, in some ways, limited in their abilities to help their daughters process their traumas, or to reassure them that they had not been to blame for the violence they had experienced. Both mothers emphasised repeatedly that a caring non-parent adult had been essential for validating their daughters' feelings and building their confidence. Future research on how violence and trauma impact those closest to the victims should explore the ways in which a person's relationship to the victim may aid or hinder their ability to support the victim through their recovery.

Another finding of this study was that the case workers of the Navigator programme were able to help build victims' confidence in social institutions, such as the police, making them more comfortable reporting instances of abuse. Future research on HVIPs should explore the possible ways in which HVIPs can build trust between community members and social institutions, such as police, social benefits agencies, healthcare services, and others. Trust

building between community members and the social institutions meant to serve them could have innumerable benefits to the long-term health of various populations.

Strengths and Limitations

One of the main limitations of this study was the small sample size. In total, there were six participants, consisting of three service providers, one member of a partner organisation, and two parents of service users. Despite the small number of participants, there was a great deal of overlap in their responses, which resulted in the identification of very clear themes and patterns during data analysis. Among the Navigators and the mothers of service users, respectively, there was almost complete data saturation. While many of the themes and ideas that emerged from these two groups were echoed in my interview with A, the member of the partner organisation, it would have been beneficial to have been able to interview more members of partner organisations about their experiences with the Navigators. Unfortunately, due to time constraints, this was not possible.

Due to a number of factors, including time constraints, no victims of IPV were interviewed about their experience of the Navigator service and how it helped them change. This is considered a weakness of the study because it is imperative when determining whether and how the service helps victims of IPV to consider, first and foremost, the perspectives of the victims themselves. However, this study was able to include the interviews of the mothers of two young women who used the Navigator service after experiencing IPV. This proved to be extremely valuable as both of these women were deeply involved in supporting their daughters through the processes of recovery. Additionally, violence does not only affect its victims. Attempting to support a loved one as they recover from trauma can be a painful, confusing, emotionally draining, and vicariously traumatic experience. Recognising this, the Navigators offer support to the family members of their

clients who have experienced violence. Thus, the mothers of service users interviewed in this study are, or have been service users in their own right.

Although the equipment used to record the interviews for this study came highly recommended, several problems occurred during the recording of interviews, including phone calls being disconnected mid-interview, and the recording device failing to record parts of interviews. Rich notes were taken during all of the interviews, and so all of the interviews were still able to be compared against each other to identify themes and sub-themes. All direct quotes used in this study have come either from the parts of interviews that were able to be recorded and transcribed, with the exception of two short quotes that were written down verbatim in the notes taken during the interviews. Fortunately, all of the participants were extremely patient and understanding throughout these technical difficulties, and there is no reason to believe that any of the responses obtained in the interviews were altered as a result of the recording issues.

Another weakness of this study may be the homogeneity of the sample. Because the participants all came from similar demographic backgrounds, it is impossible for this study to deduce whether or not any demographic factors, such as ethnicity, religious orientation, financial circumstance, etc., may impede the ability of the Navigator programme to help some service users move away from violence. Because intimate partner violence, in particular, is not socially patterned—that is, it can happen to anyone regardless of demographic background, levels of deprivation, etc.—methods of assisting victims of IPV must be adaptable to the needs of victims from all backgrounds. While HVIPs are certainly designed with this in mind, future studies should be carried out with more diverse groups of participants in order to determine how generalizable the benefits of HVIPs, and the Navigator programme really are.

Because this study utilized a non-probability sampling approach, the results are not strictly generalizable to the larger population (Bryman, 2016). Further, because the sample of those interviewed was not chosen at random, it is possible that only those who have had positive experiences with the Navigator Programme chose to participate in this study. However, the findings of this study have been largely consistent with the findings of previous studies on the benefits of HVIPs to victims of violence.

Finally, some argue that due to the nature of qualitative research, decisions regarding what findings are important are often made unsystematically and subjectively based on the researcher's views and values (Bryman, 2016). It is possible that the researcher's own ideas about which themes emerging from the data were significant may have influenced the analysis of the data. However, the findings of this study were similar to those of other studies on IPV, HVIPs, and the role of social support in building resilience. Further, the use of triangulation to compare the perspectives of three separate groups of participants was much more significant to the emergence of relevant themes and trends in the data, and thus helped to prevent bias on the part of the researcher.

# Conclusion

This was a qualitative inquiry into whether and how the Navigator programme helps victims of IPV in Glasgow and Edinburgh, Scotland move away from violence and chaotic lifestyles. The purpose of this study was to highlight the voices of those who engage with the Navigator service on the ground as service users, partner organisations, and the Navigators themselves using semi-structured interviews in order to hear, in their own words, how the Navigator programme impacts victims of IPV.

Findings indicated that, overall, the Navigator program has been extremely beneficial to the lives of the service users who were interviewed in this study. The data also showed that victims of IPV often require specialised and more sensitive care than other victims of violence, and that HVIPs, and specifically the Navigator programme may be especially well suited for connecting victims of IPV with community-based support services, facilitating a holistic treatment approach, and supporting victims and their loved ones through the process of recovery after trauma. Finally, the data also suggest that the limited reach of the Navigator programme is a major weakness, as all three groups of respondents indicated that larger numbers of trained, compassionate case workers would be the best way to improve the service. While these preliminary findings are encouraging, further investigations into how the Navigators help victims of IPV should be conducted with larger and more diverse sample sizes.

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