

What do I do when they disclose?

Responding to intimate partner violence and coercive control in primary care

Jennifer Neil, Fiona Giles,
Kelsey Hegarty

Background

Intimate partner violence (IPV), particularly coercive control by a partner, is prevalent in Australia as well as worldwide, and survivors present commonly with a range of symptoms to general practitioners (GPs). It is recommended for GPs to take a case-finding approach to identify survivors of IPV and it is important for GPs to know how to appropriately respond to disclosures.

Objective

This article outlines how to respond generally to disclosures in general practice using the World Health Organization 'LIVES' framework (Listen, Inquire about needs, Validate, Enhance safety and offer Support). We focus on enhancing safety responses to adult survivors of IPV and children affected by IPV.

Discussion

It is recommended for GPs to inquire about concerns, use validating statements and undertake regular risk assessment and safety planning for survivors and their children. Offers of appropriate referrals and ongoing support should be in the context of providing choice, control and advocacy.

INTIMATE PARTNER VIOLENCE (IPV) and coercive control¹ is common worldwide and is gendered in nature, with women being more likely than men to be survivors.^{2,3} In Australia, from the age of 15 years, one in four women and one in 14 men have been subjected to physical or sexual IPV.⁴ Coercive control is a pattern of behaviours using physical, emotional, sexual, financial and other abuse tactics.¹ IPV and coercive control are also prevalent in lesbian, gay, bisexual, transgender, queer, intersex, asexual and other (LGBTQIA+) communities.³

It is common for survivors to present in general practice. In Australia, historical prevalence studies have found that full-time general practitioners (GPs) see around five women per week who are survivors.⁵ It is also estimated that one in four women attending general practice who have a diagnosis of depression are current survivors of IPV.⁶ This article focuses on how to respond to a disclosure of IPV and coercive control in general practice. In addition, any appropriate medical responses should be tailored to patients' physical presentations. This might include analgesia, sexually transmitted infection screening, contraceptive and pregnancy counselling and management of injuries, including strangulation and traumatic brain injury.

The 5As framework: Asking about and responding to a disclosure of IPV

The 5As (are they Alone, Ask sensitively, Assess safety, be an Ally, Advocate) is a tool that has been developed based on survivor voices that GPs and primary care nurses can use while ensuring privacy to ask about and respond to disclosures of IPV (Figure 1).⁷ The 5As tool incorporates the World Health Organization's recommended 'LIVES' framework to respond to disclosures of IPV.⁸ It is recommended that GPs use a case-finding approach to ask about the possibility of IPV when certain indicators are present, which includes asking all pregnant women.⁹ The sensitive ways to ask are discussed in the article 'Issues in the identification of all members of a family affected by intimate partner violence in primary care' by Neil et al.⁹

Listening, inquiring and validating

A response to a disclosure¹⁰ should be underpinned by trauma- and violence-informed care principles to enhance the psychological safety of both the survivor and the GP or nurse.¹¹ When listening to survivors, it is important never to pressure them to tell more about their experiences of abuse and violence than they are ready to.



The Family Safety 5 As: ALONE – ASK – ASSESS – ALLY – ADVOCATE
Victim-survivor voices to guide health practitioner conversations about family violence

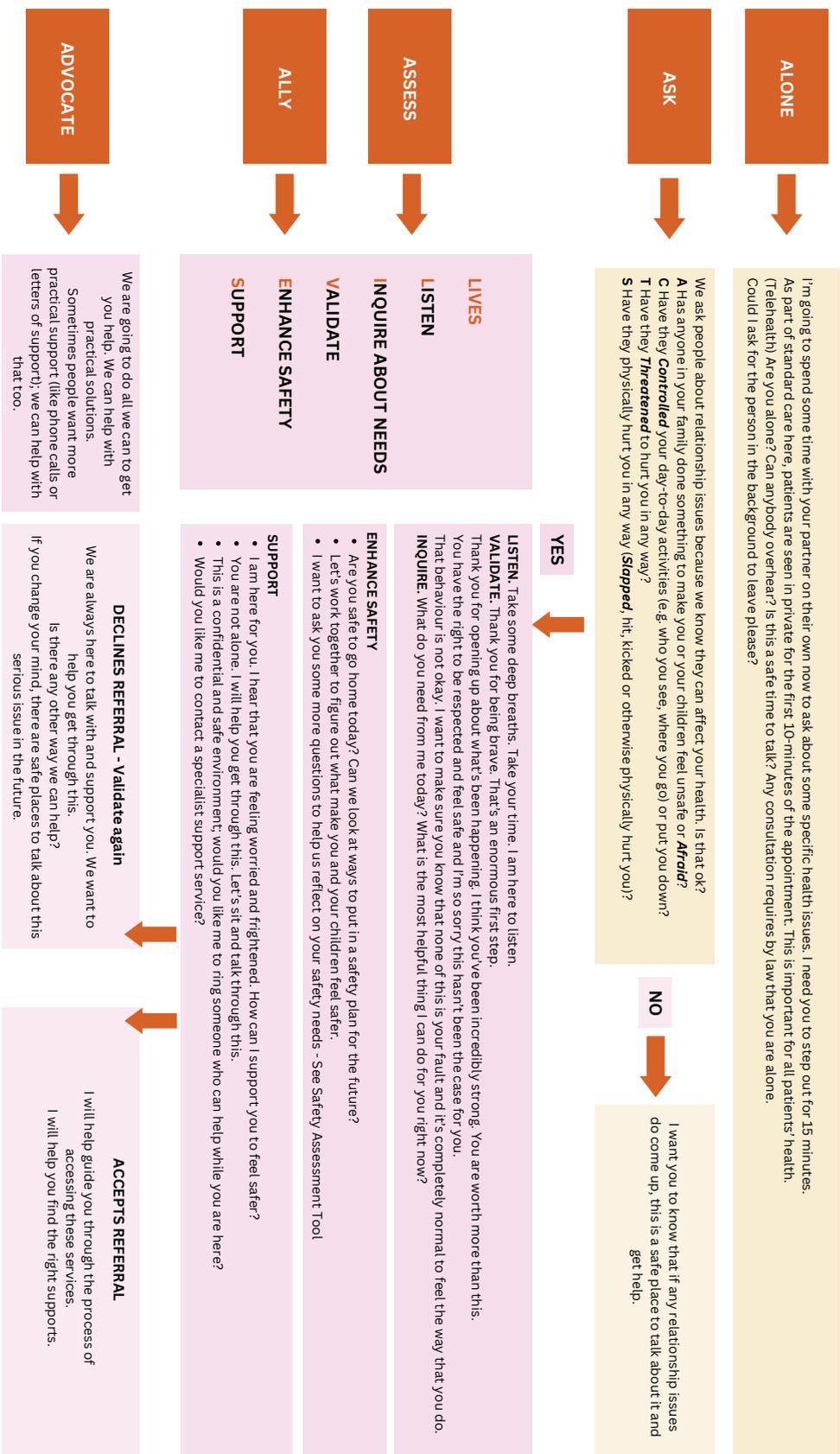


Figure 1. The family safety 5 As tool. Reproduced with permission from Safer Families Centre.⁷

It is important to believe survivors, as not believing survivors is very invalidating. When inquiring about a survivor's needs and concerns, it is important not to make assumptions about what these might be, but instead to listen carefully, remembering that the survivor is an expert in their own situation. Use of validating statements shows that the GP or nurse recognises and understands their experiences.¹⁰ It can also be very empowering for the survivor as this might be the first time anyone has told the survivor that the abuse is not their fault. Women experiencing psychological coercive control are especially vulnerable to feelings of shame, self-blame and lack of self-worth, requiring tailored responses.¹²

Enhancing safety – risk assessment

The physical and psychological safety of survivors and their families is a priority when responding.¹³ For this reason, as included in the LIVES framework, GPs and nurses can enhance safety by conducting a risk assessment and safety planning. A risk or safety assessment aims to identify the likelihood of an adverse event occurring although cannot predict all events.¹⁴ Risk changes over time; thus, the risk assessment should be reviewed at each encounter with a survivor.

To perform a risk assessment, it is recommended for the GP to take the following factors into account before making a professional judgement about level of risk:^{13,14}

- Survivor's self-assessment of their own safety
- Evidence-based risk factors
- Any information sharing that has occurred
- Intersectional factors (context of the person's background).

Survivors' self-assessment of their own safety

Survivors are the experts in their own safety as they are the person who is most familiar with the behaviour of the person who is using violence.¹⁴ For that reason, this is the most important part of the assessment. It is important to ask about the survivor's safety and safety of any children who have been exposed to IPV between adults (Table 1). Questions should be sensitively funnelled from more general to specific.

It is important to note that some survivors might sometimes minimise their level of risk due to the psychological abuse tactics used by their partner, creating denial and fear for the survivor. For this reason, it is still important to take other aspects like evidence-based risk factors into account.^{13,15}

Evidence-based risk factors

Evidence-based risk factors are factors known to increase the risk of death or serious harm (Table 1). These risk factors highlight current and past patterns of behaviour of those who use violence that put survivors at risk. The riskiest time for being killed or seriously injured is when planning to leave, leaving, or having just left a relationship. Thus, it is important to put in place support around this time and never pressure survivors to leave unless they are ready. Another very risky time for women is during pregnancy when violence often starts or escalates in frequency.¹³ Non-fatal strangulation, sexual assault and threats with weapons are particular risk factors for future homicide (seven times more likely).¹³ Also of concern is escalation in frequency or severity of violence, as these women are more likely to be killed.¹³ Psychological coercive control also puts survivors at increased risk and lethality, especially when other high-risk factors are present.¹³

Information sharing

If survivors are involved with other agencies, GPs and nurses might share information to increase survivors' safety with the survivors' permission (eg a GP might speak to a family violence worker or to the police). Some states or territories might also have specific information-sharing laws (eg Victoria's Information Sharing Scheme).¹⁶ Any information received through information sharing can be incorporated into the professional judgement of survivors' level of risk as it can give a broader picture of perpetrator behaviour.

Intersectionality

All communities of Australia are at risk of experiencing IPV; however, there are several priority populations that might experience increased risk of IPV or face significant barriers to support, much of which is due to marginalisation and discrimination.^{3,13}

These groups include but are not limited to:¹³

- Aboriginal and Torres Strait Islander women and their families
- migrants and refugees
- LGBTQIA+ people
- people living with a disability
- people living in rural and remote areas.

Table 1. Asking about survivors' assessment of their own and their children's safety

Use clinical judgement for which order the questions are asked

About the survivor

- How safe do you feel?
- Do you feel safe to go home today?
- Do you believe they are capable of killing or seriously harming you?

About the children

- Do you feel that the children are safe?
- Have they ever threatened to harm the children?
- Have they ever harmed your children?
- Do you believe they are capable of killing or seriously harming the children or other family members?

Asking about evidence-based risk factors

Has your partner recently:

- been obsessively jealous towards you?
- followed, repeatedly harassed or messaged/ emailed you?
- increased the severity or frequency of violence?
- misused alcohol, drugs or other substances?
- become unemployed?
- separated from the relationship?

Has your partner ever:

- assaulted you when you were pregnant?
- seriously harmed you?
- tried to choke or strangle you?
- forced you to have sex or participate in sexual acts when you did not wish to do so?
- harmed or threatened to harm a pet or animal?
- threatened to use a weapon against you?
- threatened to kill you?

Adapted from Chapter 3: First-line response to intimate partner abuse and violence: Safety risk and assessment, The White Book: Abuse and violence – Working with our patients in general practice, with permission from The Royal Australian College of General Practitioners^{15,28}

Aboriginal and Torres Strait Islander women are 32 times more likely to be hospitalised due to IPV than non-Indigenous women, and risks are greater for Indigenous women living in remote areas.¹⁷ Violence is not part of Aboriginal and Torres Strait Islander culture, rather, with colonisation, marginalisation and discrimination the risk of IPV has increased.¹⁷ Migrant and refugee women might face risks of multi-perpetrator abuse, visa abuse and isolation.¹³ There are significant barriers to help-seeking, including language issues, racism, isolation and lack of awareness of services.¹⁸ LQBTQIA+ people experience IPV at a higher rate than the heterosexual community.³ This is likely to be because of experiences of homophobia and transphobia and fears of being 'outed'.^{13,19} Women living with a disability are 40 times more likely to be subjected to IPV than other women and this might include specific forms of violence like withholding care (eg not giving medications or not providing personal care tasks).¹³ Rural and remote survivors face a lack of services, isolation and supports, and the person using violence might have increased access to weapons such as guns.^{20,21}

These and other intersectional factors should be considered when performing a risk assessment by acknowledging potential increased risks as well as barriers to accessing supports.

Professional judgement

Taking all four areas into account, putting most emphasis on the survivors' self-assessment of their own safety, the GP or nurse can then use their judgement with the survivor's input about the level of risk (at risk, at elevated risk or at immediate risk). Refer to Figure 2 for guidance through this judgement process for adults.

Risk assessments in children

GPs can ask survivors about the safety of their children (Table 1) and, if appropriate, talk to the children themselves.²² If GPs believe the threshold for mandatory reporting of child abuse has been reached (this is state and territory specific in Australia) then a report must be undertaken. It is important to let survivors (if they are a protective parent) know the report is being made so that they can keep themselves safe, as the person using

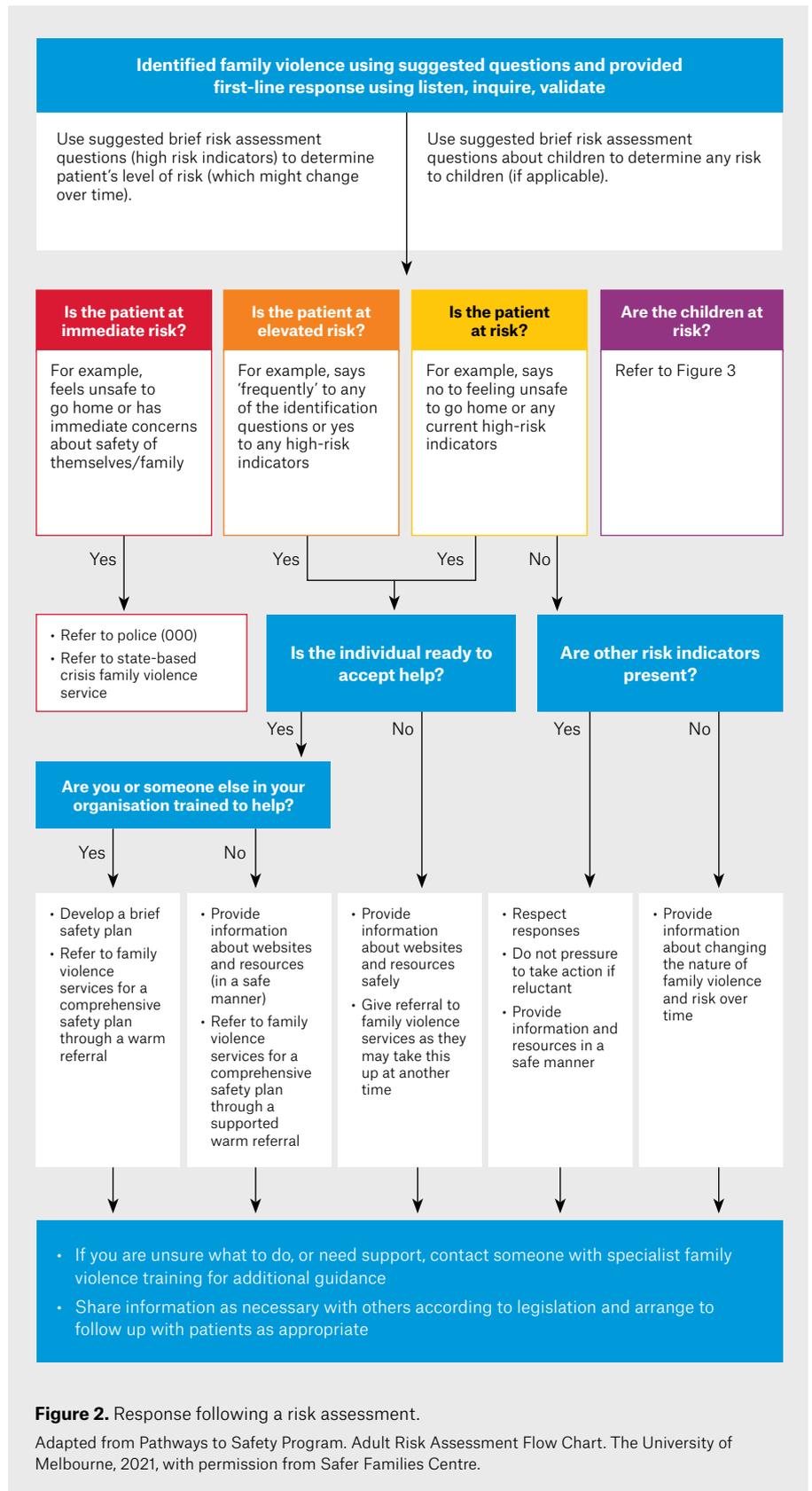


Figure 2. Response following a risk assessment.

Adapted from Pathways to Safety Program. Adult Risk Assessment Flow Chart. The University of Melbourne, 2021, with permission from Safer Families Centre.

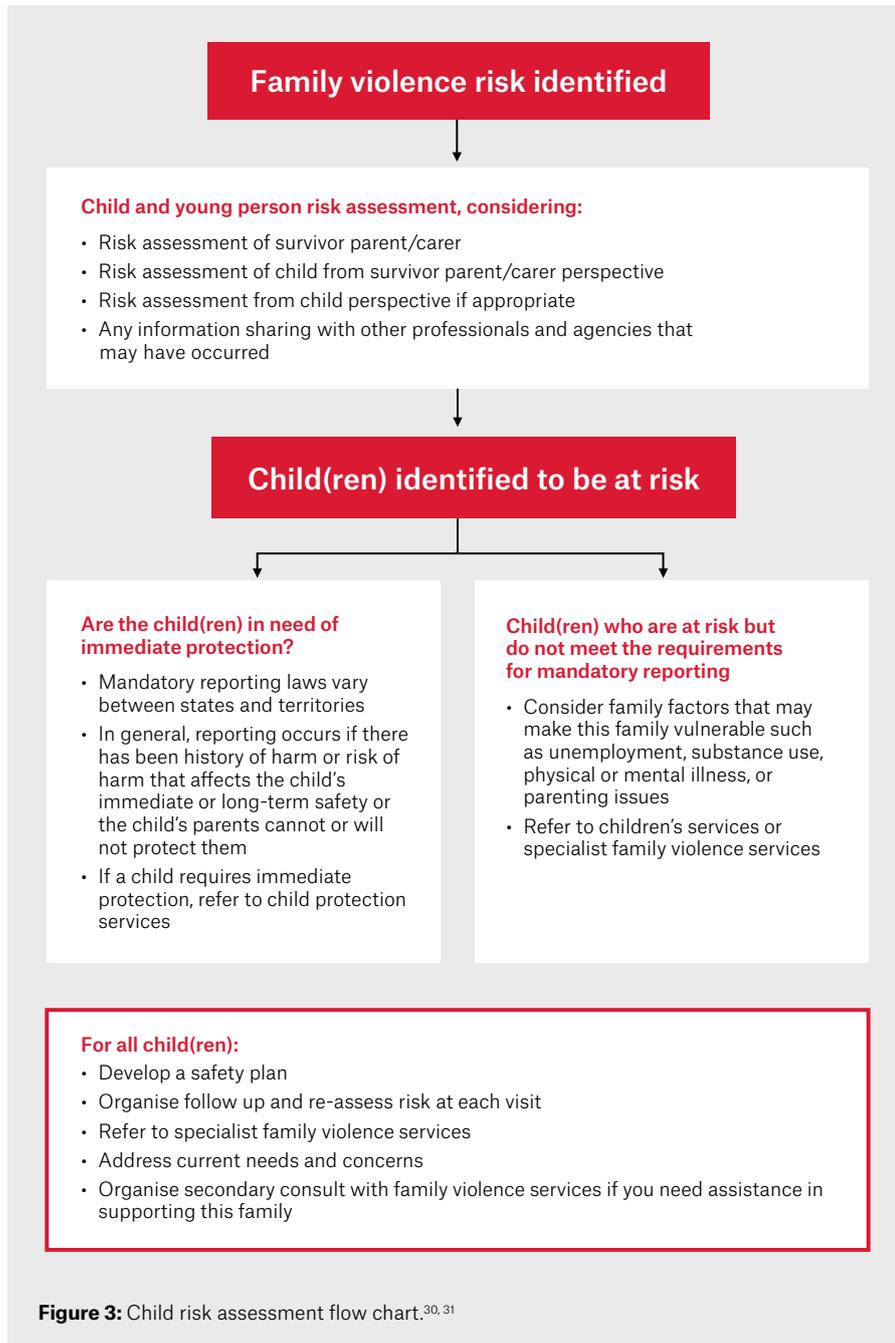
violence might be alerted to the report, which might increase risk to survivors. Mandatory reporting might affect a GP’s relationship with their patient; however, this can be minimised if rapport has already been developed and a careful explanation about the importance of keeping both children and adult survivors safe has been given. If the threshold for mandatory reporting has not been reached, it might be

appropriate to refer the child to a vulnerable children’s organisation or family violence service. A child risk assessment flow chart is outlined in Figure 3.

Safety planning

The risk assessment then informs safety planning. Survivors attending general

practice will usually feel safe to go home after their consultation and will mostly need a plan for what to do in a future crisis. If the abuse is to escalate, where will they go, how are they going to get there, what are they going to take and who are they going to take? Safety plans might need to change over time so should be revisited at each consultation (Table 2).



Referrals and supports

All survivors should be offered a warm referral to family violence services. Warm referrals are where GPs or nurses assist the patient while they are in the room together, with the patient’s consent. Workers from family violence services are experts in comprehensive risk assessment and safety planning and can speak to the patient immediately if they are at immediate risk. In addition, survivors who are at elevated risk should be strongly encouraged to take up a referral. This could be approached by the GP saying something like: ‘I am concerned for your safety at the moment, so I would like to help refer you to a family violence worker who can help to increase your safety. Would you be happy for me to help you make that phone call?’ If there is imminent risk, 000 or family violence services should be called with the survivors’ consent. For a further discussion about imminent risk and confidentiality, refer to the article ‘Issues in the identification of all members of a family affected by intimate partner violence in primary care’.⁹

There are different services in each state and territory. A list of Australian services is available in The Royal Australian College of General Practitioners’ (RACGP) White Book.²³ 1800RESPECT is a 24/7 Australia-wide service that is a useful number to give survivors and can also be accessed by clinicians for advice and support. There are also services available for priority populations, including the LGBTQIA+ community, Aboriginal and Torres Strait Islanders, and people from migrant and refugee backgrounds.

In addition, GPs and nurses have an important ongoing role in supporting survivors and their children because they have a long-term relationship with patients and have built rapport and trust. A follow-up appointment should be arranged whether

Figure 3: Child risk assessment flow chart.^{30,31}

a referral to family violence services is accepted or not. This appointment might need to consider safety concerns, especially if follow-up occurs over telehealth.²⁴

What survivors want from their GPs

The CARE model has been developed to inform health professionals of what survivors want from their GP after disclosure.^{25,10}

The CARE model involves clinicians offering the following to survivors:

- Choice and control
- Action and advocacy
- Recognition and understanding
- Emotional connection

It is important to remember that when a person is subjected to IPV, they have had control taken away from them, so offering survivors choice, control and advocacy is empowering. GPs need to reflect on their own biases when responding.

Managing the whole family

It is not recommended for GPs to manage both a survivor and the person using IPV due to the risk that they might inadvertently

break confidentiality, which could put the survivor at risk.²⁶ For further information about how to negotiate these issues, refer to Hegarty et al.²⁶

Documentation in medical records

Accurate, contemporaneous notes should be kept, being aware that notes could be subpoenaed in the future. Where possible, instead of using terms such as ‘domestic violence’ in the reason for visit, use terms that represent the initial indication for the visit, to reduce the chance of an inadvertent breach of confidentiality.²⁷ Lynch et al discuss issues around documentation of IPV in more detail, including the importance of gaining survivor consent in the documentation process.²⁷

Conclusion

GPs and nurses can use the LIVES and CARE models to guide their response to a disclosure of IPV. GPs and nurses have an important role when a survivor discloses IPV by responding in a trauma- and violence-informed way and by increasing safety through an appropriate

risk assessment, safety planning, and by offering a referral and supports.

Key points

- It is recommended to use the World Health Organization’s ‘LIVES’ approach when responding to survivors of IPV and coercive control.
- Survivors should be offered CARE: Choice and control, Action and advocacy, Recognition and understanding, and Emotional connection.
- Safety planning is an important process to enhance the safety of survivors and their children.
- Survivors’ self-assessment of their own safety is the most important part of any risk assessment.
- Safety of any children should always be considered.

Authors

Jennifer Neil MBBS (Hons) FRACGP MClinEd, Associate Professor and Head of Curriculum, Monash School of Medicine, Monash University, Melbourne, Vic
 Fiona Giles PhD, Research Fellow, Department of General Practice and Primary Care, The University of Melbourne, Melbourne, Vic

Table 2. Safety planning

Where to go?	This might be a friend or family member’s house (they should know about it beforehand) or it might be a busy shopping centre or fast-food restaurant. The survivor might be able to work out a code word to use with friends or family members to let them know they need assistance.
What to take?	A bag might be pre-packed with clothes, money, important documents or copies of documents. This might be kept at a friend’s house, in the car or somewhere safe at home. Care should be taken that it is not likely to be found as this might increase the violence.
How to get there?	Car keys or public transport ticket should be put aside. Or have an arrangement with a trusted friend or family member.
Who should I take?	If children are involved, it is important to decide beforehand if they will be coming. Survivors might need to note that some shelters do not allow boys above certain ages. If young children will be leaving, having bags packed ready for them might be important.
What supports should I contact?	If the survivor’s life is at risk or they are at risk of injury, they should be instructed to call 000. 1800RESPECT is a useful number to give survivors as it can be remembered rather than needing to be written down, which could put them at risk if found. 1800RESPECT is an Australia-wide 24/7 family violence counselling service. They will be able to connect the survivor with crisis services if needed as well as family violence services.
Technology abuse (when a person who uses violence uses technology to harass, stalk or threaten. This might involve tracking survivors, using listening or recording devices or sending abusive or threatening messages) ³²	If survivors have noted the person using violence knowing things they shouldn’t really know about or knowing where the survivor is or has been, they might be being subjected to technology abuse. It might be risky for them to use their own phone or computer. The Australian e-safety commissioner has a website dedicated to assisting survivors to reduce risk associated with technology abuse. Available at www.esafety.gov.au/women/reduce-technology-facilitated-abuse

Kelsey Hegarty MBBS, DRANZCOG, FRACGP, PhD, Professor of Family Violence Prevention, The University of Melbourne and Royal Women's Hospital, Melbourne, Vic

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Correspondence to:

jennifer.neil@monash.edu

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correspondence ajgp@racgp.org.au