Submission No 56

COERCIVE CONTROL IN DOMESTIC RELATIONSHIPS

Organisation: Doctors Against Violence Towards Women

Date Received: 28 January 2021

DAVTW
Doctors Against Violence Towards Women

The Joint Select Committee on Coercive Control

Parliament of New South Wales

6 Macquarie St

Sydney, NSW 2000

29/01/2021

To the members of the Joint Select Committee on Coercive Control,

Doctor's Against Violence Towards Women supports the criminalisation of coercive control, alongside investment in cultural change in the policing and criminal justice systems and adequate social support for victims.

Coercive control or "intimate partner terrorism" is an integral component of domestic abuse and it is a significant predictor of intimate partner homicide. Yet, the current system has police assessing individual incidents of physical violence, intimidation and stalking, without consideration of coercive controlling behaviours. This forces victims to wait till abuse escalates to physical or sexual violence before they can access help from police. It also leads police into mistaken identification of perpetrators and victims, due to violence used in self defence or retaliation[1]. Moreover, ADVOs and the criminal offence of intimidation/stalking, while helpful, have long proven inadequate to protect all victims[2].

[1] https://www.womenssafetynsw.org.au/impact/publication/criminalising-coercive-control-position-paper/
[2] https://rlc.org.au/article/do-apprehended-domestic-violence-orders-work

Doctor's encounter victims of domestic abuse regularly in clinical practice, particularly within general practice, emergency departments, obstetrics, drug and alcohol and psychiatry, but not exclusively. Over 1 in 5 women will make their first disclosure of domestic violence to their general practitioner[3]. The general practitioner is then in a position where they must assess the safety of the patient and their children, then decide on an appropriate course of action. This may include contacting the police, referring the patient to specialised domestic violence services, legal or financial services. Often, GPs are involved in making emergency plans with the patient, so that they can leave an abusive partner safely – making sure they have a safe place to go, some money, identity documents and support people around. They take this on, knowing that this patient is at highest risk of being killed by their abuser at this time and that the justice system is mostly unable to protect the victim under the legal framework that is currently available. As 111 of 112 (99%) of intimate partner homicides in NSW from March 2008 to June 2016 were preceded by coercive controlling behaviour[4], the criminalisation of coercive control is one thing that could help GPs to keep their patients safe.

Victims of domestic abuse are also frequent presenters to Emergency Departments. So much so, that in 2017 NSW health conducted a study looking at the feasibility of screening all women aged 16-45 (except those requiring urgent medical attention) for domestic violence in metropolitan and rural emergency departments. They found that of 868 women, 154 (or 17.7%) were victims of domestic violence. The screening tool used in this study focuses on physical violence, threats and emotional abuse (HITS). Patients were referred on to social work for risk assessment, safety planning, education and referral to specialist services. The study concluded that screening for domestic abuse would be supported by staff and rollout or further study should be considered[5]. The Australasian College of Emergency Medicine now recommends use of the HITS tool for screening for domestic abuse in adequately resourced Australian emergency departments[6] and in 2020, NSW health invested $1.8 million into a

[3] https://www.wlsnsw.org.au/wp-content/uploads/GP-toolkit-updated-Oct2019.pdf

[4] https://www.coroners.nsw.gov.au/documents/reports/2017-2019_DVDRT_Report.pdf
[5] https://www.health.nsw.gov.au/parvan/DV/Publications/dvs-emergency-departments.pdf
[6] https://acem.org.au/getmedia/69e7db91-5dcd-4875-a6e0-ce5760684678/Policy_on_Domestic_and_Family_Violence_Nov16.aspx

12month screening program in selected emergency departments[7]. While the HITS tool identifies a substantial portion of victims, it is likely that scales incorporating coercive controlling behaviours will identify a greater proportion of victims again.

Screening for domestic violence is also recommended by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, particularly in the context of pregnancy and early parenthood, when the risk of domestic abuse escalates[8]. Moreover, with 3 in 10 patients hospitalised due to assault identifying themselves as victims of domestic abuse[9], it can be argued that an integrated whole of hospital or health system response to domestic abuse would be helpful, to ensure that patients identified by screening receive adequate support in hospital, as an inpatient or outpatient attendee, and on discharge into the community.

However, screening and identifying victims of domestic abuse in the health care setting is only appropriate if there is something staff can do to support the victim. Doctors in our group frequently struggle to find safe accommodation for patients. Victims of financial abuse frequently fail to find funds to leave safely. Many victims do not wish to involve the police. They do not trust that the civil and criminal justice system will protect them. Victims frequently leave their GP, local emergency, obstetrics department or hospital ward into the care of their abuser, as this is the safest place for them.

If coercive control is criminalised, it would help doctors to keep victims safe, but only if the police and justice system support doctors in this aim. Significant funds and time need to be invested in re-training staff in the police and justice system and in developing domestic violence leaders in these departments, who will push for cultural change and accountability. Sentences need to be proportional and just, but adequate, to send the right message to the community. Victim safety should be a priority when perpetrators are charged and police need

[7] https://www.smh.com.au/national/nsw/emergency-department-staff-to-ask-women-about-their-domestic-violence-experiences-20201125-p56hvm.html

[8] https://ranzcog.edu.au/news/screening-for-domestic-violence

[9] https://www.aihw.gov.au/reports/australias-welfare/family-domestic-and-sexual-violence

to be equipped to keep victims safe. At the same time, criminalisation of coercive control, without investment in the legal, social and financial supports required to allow victims to leave abusive partners will stifle any benefits the legislation may have. If a victim feels that staying is safer, they will stay and they will not press charges.

Finally, at Doctor's Against Violence Towards Women we are aware that domestic abuse has a disproportionate impact on the Aboriginal and Torres Strait Islander, LGBTQI, CALD and disabled communities. We are also aware of the disproportionate rates of incarceration of Indigenous Australians in general. In drafting the legislation to criminalise coercive control, legislators should consider the potential impacts on these communities. Moreover, as doctors we strongly support investment in trauma informed, evidence based and culturally appropriate mental health and rehabilitation services to assist victims and perpetrators.

Attached to this letter are several salient quotes from our members, which further illustrate the issues doctors face when trying to help domestic violence victims and the potential benefits and limitations of criminalising coercive control. In some of the quotes, names have been removed to protect the privacy of the patient.

Sincerely,

Dr Kate Johnson

Secretary, Doctor's Against Violence Towards Women

"I had a patient where their abuser was their employer. He used to rape and strangle her, but she remained compliant as she did not want to lose her job. She was clearly being held captive and controlled. With my support this patient was able to seek help from her sons. She did not want the police involved. Either way, with many cases where there is little evidence of physical assault, an AVO probably won't be granted and if it seems too dangerous, leaving doesn't seem like a choice."- a General Practitioner

"One of my patients' parents kept her at home, installed spyware, took all her identification documents and controlled all of her bank accounts. I was able to work with her to arrange a safe place, restore her identity documents, stop the tracking and get control of her finances. She did not want to go through the criminal justice system. I think coercive control can be hard to prove and going through the criminal justice system, as it is right now, can be re-traumatising for victims. A few of my patients have been through that and it was awful for them. People from culturally diverse backgrounds can also face stigma if they seek criminal justice. I think it would be good to be able to police coercive control, but I worry that the justice system will not get it right and the process will not be safe for our patients." - a General Practitioner

"I saw a child who was an emotional and physical wreck after their mother left her abusive partner. She told me she would not place an AVO as this would 'tip him over the edge and he would kill me and the kids.'"- a Paediatrician

"It took 3years for her to understand that he was abusive. When she finally left, he tried to strangle her. She was distraught and we called the police when she was in my office. The police officer accused her, then me, of lying, and said she was overreacting. He told her the AVO was against the perpetrator damaging her things, not her, so it wasn't relevant. Then he closed the case. She fled the office. I have had so many bad experiences with the police. Sometimes I wonder if it will ever get better" - a Psychiatrist

"I am a doctor and a survivor. While I wanted to leave and had money, I could not access my bank accounts and I was not able to access public legal services, as I had money. Leading up to physical abuse and ultimately nonfatal strangulation, I was emotionally abused, years of "you are so lazy" "you are so stupid, who forgets to buy bread when they go grocery shopping." "you wouldn't be able to understand bills and tax, so I'll do it

all." I managed to leave after the strangulation attempt, after realising the high risk of homicide and mainly out of concern for my kids. If I had known what coercive control was before the abuse escalated, who knows, it could have been different." – a General Practitioner

"As a GP, I frequently see women who live in fear of the financial, psychological, sexual and social coercive control that their partners exert over them. They come to me, call 1800 RESPECT with me, because my office is their only safe space. There is the 9am patient who is in fear of her husband's verbal tirades if she doesn't have sex with him every night. He doesn't let her sleep till she has given him what he wants, so she complies even though she doesn't want to. Sometimes she calls in sick for work, because he has raped her till 2am. Then the 4pm patient who doesn't have access to her husband's finances. He does not allow her to work. He says her "job" is to stay and home and look after the kids. He says $100 per week is more than enough and if she asks for more, he breaks things and takes it out on the kids. He screamed for hours once after she simply requested money to take the kids to the movies. Now she has stopped asking for money. She is too worried he will hurt her and the kids if she asks again.

I worry about these patients. When I see the bruises, it would be easy for me tell her to just leave, report it to the police, take out an AVO. Their emotional wounds are invisible. I believe we cannot keep these women safe until coercive control is criminalised. This would help these women to regain control of their lives and improve the lives of their children." – Dr Sumeena Qidwai, General Practitioner

"As a GP, I see and support victims of domestic abuse regularly. I help them with practical matters. I treat their physical wounds, but the psychological impacts of coercive control are the most devastating. In the words of 2021 Australian of the Year, Grace Tame, "we're pretty across the idea that the physical components of sexual abuse [and] of violence are bad, but it's when we start taking about grooming… that programming, that manipulation of your mind has the most lasting impact on individuals." These victims needed emotional support long after leaving. This sort of coercive control needs to be illegal." – Dr Kelli Angwin, General Practiitioner

"Over nearly 30 years as a GP I have seen many patients who are victims of what in recent years I have learnt is coercive control, but within the current system I have struggled to keep those patients safe. Often I have been left with no option other than sending those women back to dangerous

partners. One woman in particular sticks in my mind as I believe she very narrowly avoided being murdered, instead she continues to live in constant terror of her very dangerous, but just within the law ex partner." – Dr Adele Stewart, General Practitioner