**Submission No 102**

# COERCIVE CONTROL IN DOMESTIC RELATIONSHIPS

**Organisation:** Australian Medical Association (NSW)

**Date Received:** 1 February 2021

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29 January 2020

The Hon Natalie Ward MLC
Committee Chair
Parliament of NSW
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Sent via email: coercivecontrol@parliament.nsw.gov.au

**Re: Inquiry Coercive Control**

Thank for the opportunity to contribute a submission to the Inquiry into Coercive Control.

AMA (NSW) is supportive of introducing a new criminal offence of coercive control, provided:

- healthcare workers and other frontline domestic violence support workers are given appropriate training and education on this form of abuse;
- resources for note taking for legal purposes is included in coercive control education for medical professionals;
- the criminal offence does not change current criteria for mandatory reporting;
- there is greater availability and access to domestic violence support workers for GPs and their patients to ensure an effective multi-disciplinary response;
- and more research is conducted into how health systems can adapt to this legislative change, and what measures can be put in place to ensure the best outcomes for patients who experience abuse.

Coercive control is a form of domestic abuse that involves 'repeated patterns of physical, sexual, psychological, emotional or financial abuse'. Intimate partner homicide, and other forms of intimate partner violence, are often preceded by coercive control.

As evidenced in the Discussion Paper, the NSW Domestic Violence Death Review Team Report 2015-2017 found that 99% of domestic homicides it reviewed were found to be preceded by coercive or controlling behaviour.

One woman is killed every nine days and 1 man is killed every 29 days by a partner(1).

Criminalising coercive behaviours that could lead to intimate partner violence gives people experiencing domestic violence a means of legally holding perpetrators to account – potentially intervening in an abusive situation before it escalates to homicide.

Healthcare providers, particularly GPs and doctors working in emergency departments, often encounter patients experiencing domestic and family violence. More than 20% of women make their first closure of domestic violence to their GP, and GPs are estimated to see up to five women per week who have been abused by their partners(2). After family and friends, GPs are estimated to be the most common point of contact for women seeking help in relation to abuse(3). Furthermore, it has been noted that those working in the healthcare sector would be 'well placed to recognize' a coercive controlling situation and the 'nuanced nature' of such a presentation(4).

Given the frequency with which patients disclose experiences of domestic violence to medical professionals, there is a need for doctors to be educated on all forms of domestic violence, including coercive control.

Unlike physical and sexual abuse which often results in bodily injury, psychological abuse and coercive control is much more insidious and can be harder to identify for practitioners.

Several resources are currently available, including the GP Toolkit, published by the Women's Legal Service NSW, and the RACGP White Book. Further resources that help define coercive control and provide health practitioners with a guide on how to identify indicators associated with this type of abuse are needed. This is especially relevant given the broader nature of coercive control, whose scope lies beyond the more recognisable features of physical and sexual violence. Furthermore, given the primary role GPs and other healthcare providers play in detecting and recognising domestic violence, other modalities should be employed to raise awareness of coercive control, such as broader education campaigns targeted at healthcare workers.

In addition to education on how to identify coercive control, further resources for medical professionals on note taking for legal purposes may be needed, should the victim pursue criminal charges for this abuse.

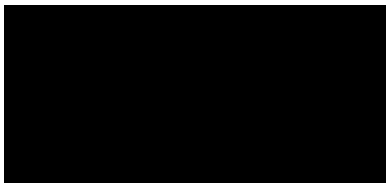
Under current mandatory reporting guidelines, if a patient talks to a medical professional about experiencing or perpetrating violence and the doctor has reasonable grounds to suspect that a child is at risk of harm, they must report this to Community Services. However, medical professionals are not obliged to report violence experienced by adults. Reporting violence experienced by adults without their consent could put them at greater risk of harm. Maintaining confidentiality and trust is crucial to developing a therapeutic relationship with the patient. Any legislative change to criminalise coercive control should not change the current criteria for mandatory reporting.

Additionally, greater availability and access to domestic violence support workers for GPs and their patients would aid significantly in ensuring an effective multi-disciplinary response. Greater visibility and accessibility of local services would also provide assistance to GPs seeking appropriate care for their patients.

As highlighted in the discussion paper, coercive control laws have been implemented overseas in countries including England, Wales and Scotland. We note that there is little to no literature on how health systems have adapted to these legislative changes. Rather, the

literature is largely focussed on how law-enforcement and the legal system responded to these changes(7). In Scotland, funding and education was provided to the police force as well as Women's Aid in reaction to the new legislation, but no funding was given to any health services or providers to aid in education in understanding the legal changes(8). Given the key position of health practitioners in identifying domestic violence and coercive control, more research should be done in identifying how health systems adapt to this legislative change, and what measures can be put in place to ensure the best outcomes for women who experience abuse.

Yours sincerely,



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