MARIE STOPES AUSTRALIA

Queensland Women's Safety and Justice Taskforce

Coercive Control Consultation Response

July 2021

Acknowledgement

Marie Stopes Australia acknowledges the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

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Introduction

The Women's Safety and Justice Taskforce (the Taskforce) is an independent taskforce that was established by the Queensland Government. The Taskforce will examine coercive control and review the need for a specific offence of domestic violence alongside the experience of women across the criminal justice system.[1]

The Taskforce will make recommendations to the Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence. It will recommend how 'best to legislate against coercive control as a form of domestic and family violence and the need for a new offence of "commit domestic violence"' in October 2021, with additional recommendations expected in March 2022.

This submission has been written in response to Discussion Paper 1, 'Options for legislating against coercive control and the creation of a standalone domestic violence offence.' We would welcome any opportunity to speak publicly on this matter. To arrange a time for a hearing please contact Bonney Corbin, Head of Policy at bonney.corbin@mariestopes.org.au.

Background

Marie Stopes Australia is an independent, non-profit organisation dedicated to ensuring sexual and reproductive health services are equally accessible to all people living in Australia. Marie Stopes Australia is the only national accredited provider of abortion, contraception and vasectomy services, and is the country's longest running provider of teleabortion. Our holistic, client-centred approach empowers individuals to control their reproductive health safely, and with dignity, regardless of their circumstances.

Through active partnerships with healthcare providers, researchers and communities, our models of care ensure the total wellbeing of our clients is supported at every stage. We currently have five clinics in Queensland and a state wide teleabortion service. We work collaboratively with, and are partly funded by, Queensland Health to support sexual and reproductive health access for all.

Consultation response

Coercive control is a form of gender-based violence that requires strategic prevention and response mechanisms across jurisdictions in Australia. This submission is structured to address selected questions in the discussion paper that intersect with sexual and reproductive healthcare provision.

A number of our partner organisations have made submissions to this consultation which we endorse, including Sisters Inside, Children by Choice, the Centre Against Domestic Abuse Inc and Women's Health Queensland. Regarding broader questions related to coercive control, Marie Stopes Australia supports any submissions and the position paper on coercive control by the Australian Women Against Violence Alliance.[2]

1. What other types of coercive controlling behaviours or risk factors used by perpetrators in domestic relationships might help identify coercive control?

Reproductive coercion is a form of violence with an extensive resource base of evidence. [3] Reproductive coercion is a form of coercive control, and is a risk factor for situations of family, domestic and sexual violence. Understandings of coercive control should incorporate the concept of reproductive coercion.

Reproductive coercion is defined as any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making.[4] Reproductive coercion can be towards or away from any pregnancy outcome, including abortion, adoption, care, kinship care or parenting.

Reproductive coercion can include:

- sabotage of another person's contraception.
- pressuring another person into pregnancy.
- controlling the outcome of another person's pregnancy.
- forcing or coercing another person into sterilisation.
- any other behaviour that interferes with the autonomy of a person to make decisions about their reproductive health. [5]

Reproductive coercion can be interpersonal, structural, or it can be a combination of both. Interpersonal reproductive coercion is more likely to occur within contexts of structural coercion. [6]

Pregnancy can be the direct result of coercion, and can tie a woman or pregnant person to an abusive partner for their lifetime. It is critical that reproductive coercion be named to, at the very least, acknowledge a diversity of victim-survivor experiences.

2. What aspects of women's attempts to survive and resist abuse should be taken into account when examining coercive control

For women living in contexts of family, domestic and sexual violence, the fight to access sexual and reproductive healthcare is a form of survival and resistance.

Research shows that people accessing abortion care may be at higher risk of intimate partner violence than the general population.[7]

In an attempt to survive and resist reproductive coercion, victim-survivors may need to access healthcare for time bound treatment options. These treatments include sexual and reproductive healthcare like sexually transmitted infection (STI) screening, pregnancy options and contraceptive options. Abortion care has strict time constraints, increasing in complexity and risk with gestation. In Australia medical abortion is currently only able to be provided up to 9 weeks' gestation, after which surgical abortion is the primary option. Surgical abortion remains largely inaccessible in many regional, rural and remote areas of Queensland.

Sexual and reproductive healthcare in Australia remains grossly underfunded. When a victim-survivor wants to access abortion but cannot afford out of pocket costs, communities step in with crowdfund fundraising measures and by dipping into organisational reserves. Non-profit women's health centres, community centres and domestic and family violence support agencies fill a health funding gap in abortion care. These non-profit and community health services cannot afford to continue subsidising healthcare access, particularly in a pandemic.

3. What should be done to improve understanding in the community about what 'coercive control' is and the acute danger it presents to women and to improve how people seek help or intervene?

Relationships and sexuality education throughout the lifespan is critical, from early learning centres to palliative care. [8] Whilst education in school settings is core, there are many opportunities to educate beyond the classroom including in universities, workplaces, care institutions, community centres and community gathering spaces. Community led, culturally safe and age-appropriate education has the power to enable community based support and referral, and to prevent coercion and violence before it occurs.

Respectful relationships education in schools should be re-aligned alongside relationships and sexuality education to encompass protective behaviours, bodily autonomy, enthusiastic consent, pride in identity and culture and community responsive health care. This would better provide protective measures for children and young people to make informed decision-making and access networks of support, particularly if they or a peer were living in contexts of coercive control. [9]

6. If you are a member of a mainstream service or represent a mainstream service provider:

a. What training relevant to coercive control and domestic and family violence is currently available in your industry?

The healthcare sector has a swathe of training options on sexual, domestic and family violence. However, learning outcomes can be inconsistent even though services need content tailored to their region and activities. There are increasing numbers of training options on coercive control and reproductive coercion. Like many health and hospitals services, Marie Stopes Australia designs and delivers a combination of in-house and external training as part of induction and continuing professional development requirements.

Ideally training should be tailored to respond to the unique sensitive enquiry and screening mechanisms that exist in each health service. It should equip all staff, including administration staff, with the relevant skills they need to move through all stages of identification, care, safety planning, and documentation. These mechanisms will always vary depending on the personalised needs of each patient, the type of healthcare provided, the type of healthcare facility involved and how much of the patient journey is digitised.

A number of community organisations including Children by Choice, Multicultural Centre for Women's Health, Women with Disability Australia, Women's Health Victoria and others also have related training and/or resources relevant to reproductive coercion. Ideally, longer term, training would be embedded within and delivered by public, private and community health services, including community centred approaches to incorporate perspectives of Aboriginal and Torres Strait Islander people and others who have experienced systemic and historic structural reproductive coercion.

b. How are you currently supporting victims of coercive control and domestic and family violence?

Patients present at Marie Stopes Australia clinics with experiences of sexual and reproductive coercion.[10] While the majority are women, some are men, some are trans, others are non-binary. It is important that any language on coercive control is reflective of this.

At Marie Stopes Australia, healthcare options counselling is available prior to all clinical appointments. Counselling records show that up to 32% of people who chose to access counselling were living in coercive contexts.[11] This rate was higher for Aboriginal and Torres Strait Islander people, up to 50% of whom were living in coercive contexts.[12] This data is not indicative of overall prevalence, rather it demonstrates coercion identified at one point in a patient journey. There are other

contact points were coercion may also have been identified, which are not indicated here.

For patients who present with experience of coercion and violence, our administrative, counselling, nursing and clinical staff move through stages of identification, risk analysis, support, options counselling, safety planning, documentation and referral. We have a complex case management team that provides wrap around support and patient pathways. Responses will vary depending on each victim-survivor's personalised safety planning and healthcare needs.

We have people of all genders present to our clinics experiencing reproductive coercion towards or away from certain health procedures or pregnancy outcomes, including contraception, abortion, tubal ligation and vasectomy. People experiencing coercion may be seeking financial support to access healthcare, linked to poverty and financial hardship, often linked to unemployment and current economic insecurity.[13] People who already have restricted bodily autonomy are facing uniquely coercive contexts, including people with disability, people on temporary visas, people who are incarcerated and people in state care.

As a non-profit healthcare provider, Marie Stopes Australia uses income from full fee-paying patients and philanthropic donations to provide bursaries to patients experiencing financial hardship. These measures support those patients to access the essential healthcare and services they want but could not otherwise afford. In the past two years the Choice Fund has provided in excess of $850,000 worth of contraception and abortion services for women and pregnant people experiencing financial hardship. During the pandemic, the number of regular Choice Fund donors, philanthropists, and the size of their donations has dramatically reduced.

This level of hardship support is not financially sustainable. For the first time in many years, Marie Stopes Australia has had to turn away women and pregnant people experiencing financial hardship who cannot afford to access their choice of healthcare. Many patients experiencing financial hardship also rely on financial support from women's health centres and sexual, family and domestic violence services. These services fundraise to cover part or all of their patients' clinical care and/or travel costs.

c. What is working well?

Sensitive enquiry enables us to prevent and respond to coercive control and reproductive coercion in clinical settings. It supports us to tailor personalised care for each unique patient. Only when care is holistically seen as physical, mental, cultural, environmental and social can we properly embed sensitive enquiry.

In order to conduct person centred and informed decision making processes, our staff sensitive enquire about risk of harm from others, risk of harm to self and risk of harm to others.[14] This enquiry process is critical to assess risk, enable space for

disclosure and to determine if informed consent can be granted. In addition to this, it enables us to consider and support patients in accessing relevant safety planning and referral pathways for ongoing care.

Any moves to criminalise coercion should be mindful of the risk of creating additional barriers for disclosure between a patient and their healthcare professional. This includes disruptions to sensitive enquiry and informed consent.

d. What could be done better?

Queensland needs to invest in sexual and reproductive healthcare strategy, policy, and healthcare provision. Foremost, the Queensland Sexual Health Strategy needs to expand content related to abortion and contraception care, considering intersection aspects of healthcare access and healthcare equity. In the context of coercive control, equitable access to health services would enable people at risk of coercion to have greater control over their own bodies and lives.

A long list of recommendations for reproductive coercion have been included in the Hidden Forces White Paper on Reproductive Coercion in contexts of family and domestic violence.[15]

60. What other risks (not mentioned in the paper) are there in implementing legislation to criminalise coercive control?

Coercive control should never be condoned. This is not to say that criminalisation is the answer. We need to move beyond police response to violence and instead look at holistic prevention and response mechanisms that benefit each and every member of our communities.

Criminalising reproductive coercion could lead to delayed presentations for sexual and reproductive healthcare. Sexual and reproductive health concerns can have chronic and intergenerational physical, mental and social health impacts[16]. The risks of these health impacts increase with delayed or late presentations. Delayed presentation of people seeking treatment for STIs can lead to future infertility and congenital conditions. Delayed presentations of unintended pregnancy can lead to unsafe abortion and unwanted births. Delayed presentations of reproductive coercion can lead to anxiety, depression, heart disease, stroke, physical violence and homicide. Due to increased complexity and risk, delayed presentations can incur higher financial costs, adding to financial stress.

Criminalising reproductive coercion, like all aspects of coercive control, risks criminalising those who we intend to empower. For example, women in abusive relationships who don't want to proceed with their unplanned pregnancy and choose to have an abortion may have partners who approach our clinical staff claiming she is being coercive as he wants her to continue with the pregnancy. Alternatively,

sometimes a woman will come to our clinic for abortion care, a and as soon as she is alone with a clinical staff member she will tell us that her partner made her come even though she wants to continue with the pregnancy. Whilst we conduct safety planning to ensure women can access their chosen pregnancy option, and support their safe accommodation through to another specialist service provider, their partners in waiting rooms or waiting in cars outside clinics claim to be victims of coercion.

The criminalisation of coercive control risks reducing agency for people with disability, Aboriginal and Torres Strait Islander people, incarcerated people, and other intersections of oppression. It is critical that legislative reforms on coercive control do not risk increasing systemic discrimination or inequity.[17] This includes considering reproductive coercion that is perpetrated by the state, in institutional care and under guardianship orders, where people have experienced coerced child removal, coerced long acting reversible contraception (LARC) and coerced sterilisation.

61. Could the risks identified above be mitigated successfully by proper implementation or other means? If so, how?

The health system has key responsibilities for the prevention of and response to coercive control. However, it lacks strategy, investment and resourcing. While health policy is led at the national level, implementation is often delegated to states and territories. Strengthening the implementation and measurement of national health policy documents requires state leadership and advocacy, of which Queensland is well placed to lead.

The *National Women's Health Strategy (2020-2030)* includes measures that prevent and respond to violence and coercion, yet is not adequately resourced. Priority Area 5 has a key measure of success to 'reduce the rate of reproductive coercion'. Since it was published, the pandemic has influenced regression rather than progression in healthcare access and equity.[18] In addition to health policy, is critical that a *National Plan to Reduce Violence Against Women and Their Children* beyond 2022 be strategised, resourced and implemented to enable long term prevention, support and recovery.

Aboriginal and Torres Strait Islander populations need community-led, researched and funded initiatives. [19] Aboriginal and Torres Strait Islander women are at higher risk of reproductive coercion than non-Indigenous women, and are more likely to experience barriers of access and equity when seeking sexual and reproductive health care. [20]

Aboriginal and Torres Strait Islander self-determination in the prevention of reproductive coercion is essential for broader health access, equity, agency and justice. Australia needs community-led, practical and structural reform that follows

through with the Uluru Statement from the Heart. The impact of the Voice could be significant for our organisation, and for others in the health sector. The experiences of COVID-19 pandemic preparedness, response and recovery has proven the benefits of investing in Aboriginal and Torres Strait Islander health leadership and health services.[21] The same should apply for investment in community led and controlled prevention of coercive control, including reproductive coercion.

64. Would requiring mainstream services (for example health and education service providers) to report domestic violence and coercive control behaviours improve the safety of women and girls?

No. The health sector is a critical space for disclosure and help seeking. Any moves to criminalise coercion should be mindful of the risk of creating additional barriers for disclosure between a patient and their healthcare professional. This applies to both victim-survivors and perpetrators of coercion. For example, how could a GP openly discuss prevention mechanisms with their patient who is at risk of perpetrating violence, knowing that it may lead to a mandatory report?

If investing in data collection and reporting, consider investment in measurement preventative mechanisms. For example, consider the number of students who have access to relationships and sexuality education, as well as respectful relationships education. Or the number of people who have access to sexual and reproductive healthcare including STI screening and contraception. Or the number of people who have had access to all pregnancy options, including abortion, adoption, kinship care and parenting; and the prevalence of barriers and enablers to those pregnancy options.

Options for legislating against coercive control

We offer caution to options 1, 2, 3, 7 and 10. It is critical that legislative reforms do not further criminalise our communities, in particular those already over represented in the prison system.

- Option 1 – Utilising the existing legislation available in Queensland a more effectively.
- Option 2 – Creating an explicit mitigating factor in the Penalties and Sentences Act 1992 (Qld) that will require a sentencing court to have regard to whether an offender's criminal behaviour could in some way be attributed to the offender being a victim of coercive control.
- Option 3 – Amending the definition of domestic violence under the Domestic and Family Violence Protection Act 2012.
- Option 7 – Creating a new offence of 'commit domestic violence' in the Domestic and Family Violence Protection Act 2012.
- Option 10 – Amending the Evidence Act 1977 (Qld) to introduce jury directions and facilitate admissibility of evidence of coercive control in similar

terms to the amendments contained in the Family Violence Legislation Reform Act 2020 (WA).

- Option 12 – Amending the Dangerous Prisoners (Sexual Offenders) Act 2003 or creating a post-conviction civil supervision and monitoring scheme in the Penalties and Sentences Act 1992 for serious domestic violence offenders.
- Option 13 – Amending the Penalties and Sentences Act 1992 to create 'Serial family violence offender declarations' upon conviction based on the Western Australian model.

We do not support options 4, 5, 6, 8, 9, 11, 12, 13. There is no need to expand or extend criminal code references to coercive control. Ending coercive control requires rethinking prevention, including how policing and justice systems risk reinforcing systemic aspects of coercive control.

- Option 4 – Creating a new offence of 'cruelty' in the Criminal Code.
- Option 5 – Amending and renaming the existing offence of unlawful stalking in the Criminal Code.
- Option 6 – Creating a new standalone 'coercive control' offence.
- Option 8 – Creating a 'floating' circumstance of aggravation in the Penalties and Sentences Act 1992 for domestic and family violence.
- Option 9 – Creating a specific defence of coercive control in the Criminal Code.
- Option 11 – Creating a legislative vehicle to establish a register of serious domestic violence offenders.

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