CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

RESPONSE TO DISCUSSION PAPER 1 - OPTIONS FOR LEGISLATING AGAINST COERCIVE CONTROL AND THE CREATION OF A STANDALONE DOMESTIC VIOLENCE OFFENCE

Children by Choice Submission to the Women's Safety and Justice Taskforce
July 2021

ABOUT CHILDREN BY CHOICE

Children by Choice provides counselling, information and education services on all pregnancy options, including abortion, adoption, alternative care, kinship care and parenting. We provide a Queensland-wide counselling, information and referral service, deliver sexual and reproductive health education sessions in schools and youth centres, and offer training for GPs and other health and community professionals on pregnancy options, reproductive coercion and post-abortion counselling.

We also advocate for improvements to law and policy that would increase women and people who can become pregnant's access to reproductive health services and information. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women and pregnant people in relation to reproductive and sexual health.

Our Annual Reports are available on our website at www.childrenbychoice.org.au.

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Acronyms:

RCA Reproductive Coercion and Abuse

CC Coercive Control

TOP Termination of Pregnancy

DFV Domestic and Family Violence

MIP Man Involved in the Pregnancy*

Introduction

Children by Choice would like to thank the Women's Safety and Justice Taskforce for the opportunity to contribute to the discussion about criminalising coercive control in Queensland.

Children by Choice has been unable to take a position on criminalising coercive control in Queensland at this time, due to the lack of expert consensus and limited evidence base. In the absence of an agreed upon definition for reproductive coercion and abuse the primary aim of this submission is to provide the Taskforce with an insight into reproductive controlling behaviours and their intersection with coercive control.

Q1. What other types of coercive controlling behaviours or risk factors used by perpetrators in domestic relationships might help identify coercive control?

An analysis of the case notes of over 100 Children by Choice counselling clients (from late 2018 to May 2021) was undertaken to facilitate this submission, which seeks to highlight and clarify definition and understanding of behaviours associated with reproductive coercion and abuse (RCA) as a form of/ in the context of identifying coercive and controlling behaviours. It is not an exhaustive list of the behaviours described by our clients. Variability in definitions of RCA, including potential perpetrators and the concept of 'intent', continue to hinder efforts to measure and describe RCA, although debate across and within sectors, and with academics working in this space, are supporting and progressing definitional development and decision making.

Our analysis identifies reproductive coercion and abuse as encompassing a range of coercive and abusive behaviours, perpetrated by both men involved in pregnancies (MIP) and family members (usually immediate) of either the pregnant person or the MIP. In many (although not all) of the cases we've identified, the behaviours described by our clients were known or assumed to have been intended to cause pregnancy, or convince or force a pregnant person to continue or to terminate a pregnancy. We have identified a large number of instances, however, where the intention of reproductive controlling behaviours appears to be primarily focused on diminishing a pregnant person's autonomy and control over their bodies and lives, and is not focused on achieving a particular pregnancy outcome (such as continuing or terminating a pregnancy).

* While we use the term 'man involved in the pregnancy' we recognise that not all people involved in conception identify as men.

Reproductive controlling behaviours described by our clients, as documented by Children by Choice counsellors, span a spectrum of behaviours from emotional manipulation, 'persuasion' and threats to physical and sexual abuse, and complete withdrawal of financial or emotional support. Physical and sexual abuse is most often, although not always, described to us as having been perpetrated by partners or ex-partners. Withdrawal of support is a technique employed by both MIP in pregnancies/partners and family members to 'force' a certain pregnancy outcome.
Due to the nature of our work, and likely also due to the gendered nature of RCA in which it exists in a context of unequal power distribution – within families, relationships, across age groups, organisations and legal systems – all cases of RCA identified in our case notes have been experienced by pregnant women. We have little data that speaks to whether a proportion of our clients do not identify as women, however almost all clients are or have recently been pregnant at their time of contact with our service.

Of particular interest in this analysis, and possibly one of the first times this has been formally documented (given published data on RCA remains incredibly limited), we have been able to identify behaviours that are most often employed by RCA perpetrators in relation to the direction of coercion.

'Reproductive coercion' to pregnancy is closely linked to/often synonymous with sexual assault, described by our clients as behaviours including:

- **Sexual assault** that causes a pregnancy, including non-consensual sex with people while they're unconscious (asleep or, often, drugged) or as a pattern of ongoing assault by partners or non-partners, whereby the intention to cause pregnancy is often unknown to us.
- **Forced sex,** including 'giving in' to persistent demands for sex (intention unknown beyond 'sex), or for sex to 'get [them] pregnant'.
- **Contraceptive sabotage** that can include destroying a person's prescriptions.
- **Stealthing**, most often described as removal or non-use of a condom, despite agreement it would be used. Whether perpetrators of stealthing intend to cause pregnancy is often unclear in cases of stealthing described by our clients.

CASE STUDY: Gemma's (pseudonym) partner was going to prison. He destroyed her pill scripts, blocking her access to contraception. She describes that he wanted to get her pregnant so he would have a place to return to (with her and the child) when he finished his sentence.

Coercion to continue a pregnancy is commonly perpetrated via (including but not limited to):

- **Emotional manipulation**, including ongoing "pressure" to continue, verbal abuse, use of guilt, complete withdrawal of communication, perpetrated by MIP and family members, who are most often parents of the pregnant person or the MIP.
- **Threatening to kill or harm** the pregnant person if they don't continue the pregnancy.
- **Threatening to kill or harm** the pregnant person's **children.**
- **Threatening legal action** if a pregnancy is continued (such as to take full custody of resulting children, or to have a child removed).
- **Refusal to discuss** or support pregnancy options.
- **Coordinated pressure** from multiple family members, or the MIP and their family members.
- **Physically preventing** a pregnant person from **accessing healthcare** and/or TOP appointments by spending budgeted money (often on multiple occasions) *and* refusing to be a support person at a termination, and/or physically abusing the pregnant person to prevent them accessing healthcare or TOP.

Forced sex resulting in pregnancy is followed by coercion to continue a pregnancy for a number of our clients.

CASE STUDY: Sam's (pseudonym) long term partner was violent and coercive. She regularly experienced emotional and physical violence. Her partner prevented her access to money and technology, and had previously controlled the timing of her pregnancies. Despite having been told another pregnancy would be dangerous for her, Sam's partner prevented her access to contraception, resulting in the current pregnancy.

Coercion to terminate a pregnancy is commonly characterised by:

- **The withdrawal of support** for the pregnant person, including:
    - *Emotional support*: refusing to discuss pregnancy options or the pregnant person's emotions, leaving the room when conversations arise or outwardly stating a refusal to discuss the topic, or becoming uncontactable.
    - *Practical support*: refusing to pay for a termination but offering to support a child; offering financial support for a termination but threating to leave a relationship and not support a child if a pregnancy is continued.
- **Forcing the pregnant person to sign** a document freeing the MIP of any responsibility or liability in regards to the fetus/child.
    - *The relationship:* threatening to end the relationship if the perpetrator's desired pregnancy outcome isn't realised, including parents threatening to end support if their children don't seek terminations, support being both practical (such as accommodation) and the relationship more broadly
- **Physical violence,** including hitting or kicking the pregnant person's stomach.
- **Threatening suicide** if the perpetrator's desired pregnancy outcome isn't realised.
- **Emotional persuasion and/or blackmailing,** perpetrated by partners and family members, including using age or existing health conditions as arguments against or justification for withdrawing support for a pregnancy, name calling, 'yelling' and verbal abuse.

CASE STUDY*:* Sally (pseudonym) speaks to us from the waiting room as she waits to be taken in for her TOP appointment. She lives with her Mum and has a boyfriend she sees regularly, who is also the MIP. She's not sure if she wants a termination, but her partner and Mum both convinced her make the appointment. Her boyfriend threatened to end their relationship if she doesn't have a termination.
This case study indicates that RC may not always exist within relationships that are otherwise characterised by coercive control or DFV.

CASE STUDY: Emily (pseudonym) lives with a female family member/guardian. On finding out her period was late, her guardian swore at her, "you better not be f***ing pregnant". Emily hadn't shared that information with her guardian and was uncomfortable she knew this. She was worried that if she stayed pregnant her guardian's behaviour could have become more abusive. However, Emily's boyfriend also wanted her to have a termination, and as she would be reliant on him if she wanted to leave her guardian's house, her ability to make an autonomous decision was severely constrained.

Reproductive coercion to both pregnancy and TOP

Close to a third of our clients describing experiences of RC to our counsellors report coercive behaviours towards both continuing and terminating a pregnancy. Rather than reflecting a 'change of mind', this pattern of behaviour often appears to be aimed at controlling the pregnant person's

life and autonomy, and seemingly isn't driven by a preferred pregnancy outcome. Examples of such behaviours demonstrated in our data include:

- Frequent instances of a MIP having "convinced" a person to stop using contraception and then threatened to end the relationship or marriage if the resulting pregnancy isn't terminated.
- Forced sex, sexual abuse or stealthing, including perpetrating these behaviours with the intention of causing a pregnancy, followed by verbal abuse to continue pregnancy, followed by emotional manipulation to termination.
- Refusal to support a 'girl child', including pressure to become pregnant followed by pressure to terminate.
- Constantly changing their mind, including pressure (using a range of emotional and/or physical behaviours described above) to continue a pregnancy, followed by pressure to terminate.
- Not allowing the pregnant person to seek counselling or healthcare.
- Blaming and verbally abusing the pregnant person for not seeking a TOP, while simultaneously refusing to support accessibility of TOP.

CASE STUDY: Ella's (pseudonym) partner convinced her to stop using contraception, but when she got pregnant he threatened to end their marriage if she didn't get a TOP. Given a history of physical and emotional violence, Ella decided she'd had enough and ended the relationship. Post break-up her ex-partner stalked her, damaging her extended family's property.

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

Clients of the Children by Choice counselling service often recount ways in which they attempt to maintain bodily autonomy in the effort to survive and resist abuse, including coercive control. For many, access to sexual and reproductive healthcare is paramount in their safety planning.

Healthcare workers must be trained and supported appropriately to recognise and respond to disclosures of reproductive coercion and sensitively enquire about other forms of coercive control and/or physically violent behaviour.

Preventing coerced pregnancy is important particularly as rates of violence and control perpetrated against the woman or pregnant person may start or become more frequent and intense during pregnancy[12].

For some clients attempts to prevent pregnancy and resist coercive controlling behaviours include the use of contraception that is less vulnerable to detection or sabotage from the perpetrator and/or accessing TOP care and/or the withholding of information about pregnancies or pregnancy outcome decisions to avoid anticipated coercive or violence reactions.

- "He is not aware of the pregnancy because he would make me have it" (Children by Choice client).
- "It 'would be bad' if he found out she terminated the pregnancy so will say she miscarried" (Children by Choice Counsellor).
- "He would coerce her to continue the pregnancy if he knew termination of pregnancy was still possible so she is flying under the radar from him." (Children by Choice Counsellor).

Part 1 – How is coercive control currently dealt with in Queensland?

Community Attitudes

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?

Community education must be implemented across the lifespan with the aim of raising awareness and understanding of coercive controlling behaviours including reproductive coercion. Primary prevention of DFV must be a primary goal in the delivery of community education.

Mainstream services

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?

Broadly there is lots of training available on domestic and family violence within the Women's Health and Community Sector. There is a gap in provision of less recognised forms of coercive control and domestic and family violence like reproductive coercion.

Children by Choice offers specialist training on reproductive coercion but the delivery of this training is restricted by our organisation's capacity to self-fund this work. As such, the delivery of this training could have a much greater reach with more financial investment.

The learning outcomes for Children by Choice's Introduction to reproductive coercion, contraceptive options & Applied Practice training include:

- The intersection of domestic violence, unplanned pregnancy and abortion.
- Reproductive coercion as a perpetrator practice.
- Diversity, young people and reproductive coercion.
- Strategies for increasing reproductive autonomy for women.
- Screening and responding to unplanned pregnancy risk.
- Supporting women's pregnancy decision making in the context of domestic violence.
- Assisting women to access contraception less vulnerable to detection and sabotage.
- Patterns of violence during pregnancy and the practice implications.
- Discussion, reflection and self-care.

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

A third of the work in our counselling service is with clients who have experienced violence[3]. We offer decision making counselling, post and pre abortion counselling, we refer clients to external services for ongoing crisis support. We offer financial support for people accessing TOP and related expenses such as accommodation and travel. We also run an abortion doula program which provides extra support to some of our most vulnerable clients.

Provision of support for people seeking TOP services in contexts of coercive control and DFV is further delayed and complicated when SRH services, including abortion services, aren't available or accessible within close proximity to their place of residence. For example, recent changes with provision of TOP by Marie Stopes Australia in regional Queensland pose significant threats to the wellbeing of regional and rural pregnant people experiencing coercive control and DFV. The need to travel long distances for TOP and to have a support person accompany them for surgical termination of pregnancy appointments is a significant barrier for our most vulnerable clients.

Part 2- How do other jurisdictions address coercive control?

2.1 With respect to each jurisdiction's model (legislative and policing):

a. What do you think are the benefits and risks of the model?

Children by Choice recognises that the evaluation of the law, to be tabled in Parliament after 3 years of the law being in place, built into the Scottish model was regarded as a benefit. The Scottish model also contained data driven standards of criminalisation levels for women. Similar models based on appropriate Australian data, not just population data should be considered if coercive control is to be legislated against.

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

There are concerns that criminalising reproductive coercion explicitly would create additional barriers to disclosure if the affected person were concerned their partner would be incarcerated or that a legal response would endanger their individual or family's safety[4].

A person who may not otherwise disclose RCA might tell a health provider within a therapeutic setting about an unwanted pregnancy or one too close to a previous pregnancy. A discussion about these RCA symptoms may be a sign to prompt further enquiry about all aspects of DFV given the association with other forms[5].

Mainstream services should not be required to report coercive controlling behaviours including reproductive coercion as this could hinder disclosure and interfere with best practice when supporting a client experiencing DFV, CC and/or RC.

[1] Australian Bureau of Statistics (ABS). (2012). 4906.0 - Personal Safety, Australia, 2012. Australian Bureau of Statistics. Retrieved 2 July 2015, from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0;
[2] Burch, R. L., & Gallup, G. G. (2004). "Pregnancy as a stimulus for domestic violence." Journal of Family Violence, 243-47.

[3] Children by Choice. (2020). "2019/2020 Annual Report." Retrieved July 2021 from https://www.childrenbychoice.org.au/images/19.20_Annual_Report_compressed_1.pdf

[4] Heron, R.L., & Eisma, M.C. (2021). Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. Health Soc Care Community, 29: 612–630.

[5] NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care. (2021). Women's Sexual and Reproductive Health COVID-19 Coalition: A Consensus Statement on Reproductive Coercion. In preparation for publication.