Coercive control

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KEY STATEMENT

The Australian College of Nursing (ACN) is committed to supporting a nursing workforce equipped to identify and appropriately respond to instances of coercive control, and to advancing nurse leadership in fostering safe and inclusive communities. ACN considers the role nurses play in recognising and safely intervening in coercive control and abuse among those they care for as critical in reinforcing healthy relationships that ensure wellbeing, autonomy and freedom.

PURPOSE

This position statement has been developed to highlight the significant leadership role nurses have in preventing, identifying and addressing patterns of coercive control. It is intended to provide nurses with both an understanding of the current legislative and policy landscape around coercive control, and practical guidance in recognising warning signs of coercive control and opportunities to intervene safely. In addition, ACN aims to bolster existing calls to promote a consistent definition of coercive control, advocate for more nuanced screening tools and develop mandatory training for nurses as frontline health workers and first responders (Fitz-Gibbon, Walklate, & Meyer, 2020)

BACKGROUND

'Coercive control', sometimes referred to as 'intimate terrorism' is a term used to describe the ongoing, insidious nature of domestic and family violence (DFV), particularly where the abuse is not physical, but pervades the victim-survivor's everyday life (Myhill & Hohl, 2016). This pattern of coercion can manifest through social and financial control, threats and actual harm to children or pets, surveillance and technology-facilitated abuse, and isolation from loved ones, among many other tactics (Lamone, 2019). It is the leading risk factor in intimate partner homicides, with some perpetrators displaying no outward physical violence before murdering their partner and or children (Coggan, 2020; Hughes, 2020). A NSW review of DFV homicides found 99 per cent of cases involved patterns of coercive control behavior towards the victim in the lead up to their death (Parliament of New South Wales, 2020). When victim-survivors manage to leave the abusive relationship, this does not signal the end of coercive control (Costello & Backhouse, 2019; Laing, Humphreys, & Cavanagh, 2013; Stark & Hester, 2019). Post-separation violence has been identified in up to 90 percent of victim-survivor experiences, necessitating ongoing support from health professionals (Stark & Hester, 2019). In addition to being subject to coercive control themselves, children can be weaponised against victim-survivors (Laing, Humphreys & Cavanagh, 2013; Stark & Hester, 2019). Child maltreatment is also perpetrated by 80 percent of men where the dynamic of coercive control exists (Costello & Backhouse, 2019). With some exceptions, coercive control is used almost exclusively by males to victimise women (Stark, 2007), though studies suggest both violent (6.5%) and non-violent (5.4%) forms of control are used in same-sex relationships (Frankland & Brown, 2014).

While some states and territories in Australia recognise coercive control through civil law, Tasmania remains the only state with criminal offences addressing aspects of coercive control, albeit rarely used (McMahon & McGorrery, 2017). There is currently no national criminal legislation related to coercive control. Many advocates in the DFV sector argue for the introduction of both state and national criminal offences (McGorrery & McMahon, 2019; Snell, 2020), while others argue introducing such legislation without a strong evidence-base from other jurisdictions may have unintended consequences for victim-survivors (Fitz-Gibbon et al., 2020). For instance, victim-survivors from marginalised groups such as Aboriginal and Torres Strait Islander peoples (Douglas & Fitzgerald, 2018), those from culturally and linguistically diverse groups (CALD) (Gleeson, 2020; Judicial College Victoria, 2013), and those living with a disability (McVeigh, 2015) may be particularly vulnerable; to being criminally sanctioned themselves via legal loopholes for offenders, to falling through the cracks, or being further traumatised through difficult criminal justice processes (Gleeson, 2019; Hughes, 2020; Meyer, 2011).

Coercive control has been criminalised in some jurisdictions internationally, with the UK providing particularly salient case studies and frameworks for potential implementation in Australia (BBC News, 2019). Following several high profile cases of coercive control ending in homicide, various members of parliament (MPs) from both QLD (Zillman, 2021) and NSW (Agar, 2021; Boltje, 2020; Coggan, 2020; Fuller, 2020) have introduced bills to criminalise coercive control, largely based on UK models.

Figure 1 below represents the Power and Control Wheel, which forms part of the 'Duluth Model'. In each of the middle segments, a tactic of abuse is highlighted. These tactics are often used by perpetrators of coercive control in order to exert their power and control over the victim-survivor. As this model was originally developed in 1981, some critics argue it should be updated, to include the perspectives of minorities (Chavis & Hill, 2009), to recognise that for many victim-survivors, physical or sexual violence is not the most difficult aspect of the abuse (Gleeson, 2019), and to reflect the use of technology in perpetuating coercive control, through surveillance and tracking, image-based abuse and abusive calls and messages (Havard & Lefevre, 2020).

Fig. 1. Power and Control Wheel.
Source: Domestic Abuse Intervention Programs 2017. https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf

THE ROLE OF THE NURSE

Screening

As frontline health care workers and first responders in instances of DFV, nurses play a critical role in supporting victim-survivors of coercive control (Dragon, 2015). ACN believes nurses should lead efforts to recognise, prevent and address the insidious and devastating impact of coercive control on individuals, families and society more broadly.

Currently, health care workers use risk assessment and screening tools such as the 'HITS' tool (hurt, insult, threaten, scream) (Sherin, Sinacore, Li, Zitter, & Shakil, 1998) and 'HARK' (humiliation, afraid, rape, kick) (Sohal, Eldridge & Feder, 2007). While tools such as HITS and HARK provide relatively effective screening for physical violence (Iverson et al., 2013), they may not adequately equip nurses and other health care professionals to recognise the warning signs of non-violent coercive control. For instance, there may even be elements of coercive controlling behavior that nurses or midwives perceive as positive if viewed in isolation, such as an expectant father who attends every appointment or appears actively involved in care decisions. If the nurse praises or supports this behavior, it may discourage the victim-survivor from confiding in the nurse, even if directly asked screening questions.

Due to the subtle nature of coercive control and often manipulative tactics of perpetrators, it can be difficult for health care professionals to recognise signs. However, nurses are advised to look out for:

- A partner who insists on accompanying the patient to all health care appointments, no matter how routine or minor
- A partner who is domineering in health care discussions, even when the patient can advocate on their own behalf
- A partner who insists on managing the patient's payments or appointments
- A partner who is speaking on behalf of a patient from a CALD background where there is a language barrier
- An adult child who is speaking on behalf of a parent from a CALD background where there is a language barrier
- Indications the patient is afraid to undergo certain medical procedures or take certain medications because their partner may not approve
- A patient who is afraid their next of kin will be notified of any appointment or treatment, particularly when it relates to reproductive health.

As noted, particularly where health care consumers are from a CALD background, the importance of employing professional, independent interpreters is paramount. In abusive relationships, the perpetrators can take advantage of any language barrier to exert yet more control over the victim-survivor, who may be unable to articulate their own needs and preferences safely.

Referral

If a nurse believes a patient in their care is a victim-survivor of coercive control, they can refer them to available support services and resources. For instance:

- The National Sexual Assault, Family & Domestic Violence Counselling Line: 1800RESPECT
- State-based services such as:
  - ACT: Domestic Violence Crisis Service: (02) 6280 0900, available 24/7.
  - NSW Domestic Violence Line: 1800 656 463, available 24/7.
  - Sydney Homeless Connect: 1800 152 152, available 24/7.
  - QLD DV Connect: 1800 811 811, available 24/7.
  - VIC Safe Steps Family Violence Response Center: 1800 015 188, available 24/7, or (03) 9322 3555.
  - WA Women's Domestic Violence Helpline: 1800 007 339, available 24/7, or (08) 9223 1188
  - SA Women's Safety Services: 1300 782 200.
  - TAS Family Violence Response Referral line: 1800 633 937, available 24/7.
  - NT Dawn House: (08) 8945 1388, 8 am – 4 pm, Monday–Friday. Outside these hours, calling 000 is advised

Data collection

Nurses can also play a critical role in reporting suspected or confirmed instances of coercive control, provided this is done in a safe and appropriate way, according to best practice principles and reflective of the victim-survivor's dignity and autonomy. These data can be used not only for statistical purposes but may also provide crucial evidence in any subsequent criminal, civil or family court proceedings.

RECOMMENDATIONS

ACN contributions

1. ACN to lead advocacy efforts to ensure nurses who are victim-survivors are supported and protected through access to DFV leave, services such as emergency housing, food provisions, childcare and counselling. Until nurses themselves have accessed adequate support services, they are unlikely to refer patients, even with the best training and risk assessment tools available.
2. ACN to join leading advocacy groups in promoting a nationally consistent definition of DFV that acknowledges the insidious, devastating impact of coercive control, even where no signs of physical violence are present.
3. ACN to collaborate with existing state-based DFV providers of best practice training for health care workers (Education Centre Against Violence, 2021), to develop and implement national, nursing-specific modules and screening tools across all health care settings. Once established, this training should be mandatory to equip all nurses with the skills to recognise the insidious pattern and warning signs of coercive control, follow evidence-based risk assessment and management strategies to safely and effectively intervene. This will protect the victim-survivor and health care workers and prevent further escalation of abuse.
4. ACN to lead advocacy efforts for access to health care for victims of DFV and encourage the Australian Government to consider policy and funding alternatives to improve the capacity of the primary health care system to respond to DFV including coercive control.
5. ACN to support work to improve the capacity of the primary health care system to respond to DFV including coercive control, increasing access to counselling, and exploring options to improve data collection about DFV in general practice and primary health care settings.

Government contributions

1. The Australian Government consider a Medicare item for DFV counselling in recognition of its importance for a victim-survivor's recovery.
    a. Short term: Australian Government to consider a Medicare item number for a wraparound package of care including DFV counselling and therapeutic services distinct from a general practitioner mental health treatment plan. Nurse practitioners should be eligible to access this item number.
    b. Long term: consideration to be given to establishing a Medicare item number or a similar mechanism that will allow medical practitioners, including nurse practitioners to record a DFV–related consultation or procedure and so more accurately ascertain the public cost of DFV.

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