Women’s Participation in Domestic Violence Health Policy Development

Australian Component

Research Report

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A CIHR Global Health Research Initiative planning grant supported the development of an existing partnership between the University of Calgary and Edith Cowan University, Perth, Australia to include partners in Afghanistan, Bangladesh and Thailand and planning for a shared international research program advancing knowledge of participation in and gender analysis of health policies with the focus of addressing domestic violence. A five-day face-to-face meeting brought the team members together to develop the program of research, and a pilot project was selected as the most appropriate beginning to assess our capacity to conduct research in five countries, to communicate with stakeholders, and identify future collaborators. The project, supported by a Global Health Research Initiative pilot project grant, was designed to investigate the participation of women in the development and implementation of effective domestic violence health policies. Research was conducted by local teams in each of the five countries, and resulted in individual country reports, as well as a comparative report, which are all available on the website.


Women’s Participation in Domestic Violence Health Policy Development: The Southern Alberta Aboriginal Community [Canada]. Wilfreda E. Thurston, Jennifer Hatfield, Leslie Tutty, Cora Voyageur & Amanda Eisener. December 2006


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The views expressed in these reports are solely those of their authors, and not the Canadian Institutes of Health Research or the Center on International Cooperation.
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<td>Armadale Domestic Violence Intervention Project</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<td>DCD</td>
<td>Department for Community Development</td>
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<td>PBS</td>
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<td>Supported Accommodation Assistance Programme</td>
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Background

The Health Sector – The Australian Context

According to the World Health Organisation (2003) the Australian health system is world-class in both its effectiveness and efficiency: Australia consistently ranks in the best performing group of countries for health life expectancy and health expenditure per person.

The health system in Australia, however, is complex. Many types and providers of services and a range of funding and regulatory mechanisms exist. Service providers include medical practitioners, other health professionals, hospitals and other government and non-government agencies. Funding is provided by the federal government, state and territory governments, health insurers, individual Australians and a range of other sources. Overall coordination of major components of the health care system is provided by the Australian Health Ministers’ Advisory Council (AHMAC) – a committee of the heads of the Australian government, state and territory health authorities, and the Australian Government Department of Veterans’ Affairs. AHMAC advises the Australian Heath Ministers’ Conference on policy, resources and financial issues.

Almost 70% of total health expenditure in Australia is funded by government, with the Australian government contributing 2/3 of this, and state, territory and local governments the other third (Australian Institute of Health and Welfare, 2004). The Australian government’s major contributions include the two national subsidy schemes, Medicare and the Pharmaceutical Benefits Scheme (PBS). These schemes subsidise payments for services provided by doctors and optometrists, and for a high proportion of prescription medications bought from pharmacies. The Australian and state and territory governments also jointly fund public hospital services.

The Australian Institute of Health and Welfare (2004) suggests that between them, these arrangements aim to give all Australians – regardless of their personal circumstances – access to adequate health care at an affordable cost or no cost. There are also special health care arrangements for members of the defence forces, and for war veterans and their dependants.

Many patients’ first contact with the health system in Australia is through a general medical practitioner (GP). Patients can choose their own GP and are reimbursed for all or part of the GP’s fee by Medicare, depending on the GP’s billing arrangements. For specialised care, patients can be referred to specialist medical practitioners, other health professionals, hospitals or community-based health care organisations.

Patients can access public hospitals through emergency departments, where they may present on their own initiative, via the ambulance services, or after referral from a medical practitioner. Public hospital emergency and outpatient services are provided free of charge. Patients admitted to a public hospital can choose to be treated as public or private patients. Public patients receive treatment from doctors and specialists nominated by the hospital, but are not charged for their care and treatment.
Patients treated in a private hospital — or as a private patient in a public hospital — can select their treating specialist, but charges then apply for all of the hospital’s services (such as accommodation and surgical supplies). Medicare subsidises the fees charged by doctors, and private health insurance funds contribute towards medical fees and the hospital costs for insured patients.

Many Australians purchase private health insurance, with around 49% of the population covered for hospital and/or ancillary benefits in early 2004 (Australian Institute of Health and Welfare, 2004). Unlike other countries, such as the USA, there are virtually no employer-based health insurance schemes in Australia. In response to a significant decline in health insurance membership towards the end of the last century, the Australian government introduced various incentives to encourage uptake and retention of private health insurance — notably a 30% rebate on membership fees and Lifetime Health Cover. Lifetime Health Cover recognises the length of time a person has had hospital cover, such that people who take out hospital cover before the age of 30, and maintain their hospital cover, will pay lower premiums throughout their life compared to someone who joins when they’re older.

Complementing the services outlined above is the availability of dentists and other private sector health professionals, emergency ambulance services (not provided free of charge for most Australians) and the provision of public health services.

**Health Implications of Family and Domestic Violence for Australian Women**

In Australia the role of the health sector in the process of the prevention of family and domestic violence has taken a secondary role to that of the legal system. The important role of criminal sanctions in the process of prevention of family and domestic violence is widely acknowledged (see for example, Office of Women’s Policy, 2002; Busch and Robertson, 1994). Criminalisation has long been acknowledged in the literature and on the ground in service provision as performing a function that is both highly symbolic as well as enforcing legal and social norms (Holder, 2001). Historically, those committed to the prevention of family and domestic violence have made considerable efforts to reform the justice system to ensure that it applies the same standards of non-violence in public places into women’s intimate relationships. Indeed, this is the focus of prevention and remedial services afforded to women victims of family and domestic violence in Western Australia (WA). The role of the health sector is underdeveloped, particularly considering the health implications for women who experience family and domestic violence.

According to WHO (2002)

“women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related symptoms, pain syndromes, phobias, chemical dependency, substance use, suicidality, somatic and medical symptoms, negative health behaviours, poor subjective health and health service utilization”

In Australian women, the same scenario is evident. To establish the health problems found to result from family and domestic violence, a review of relevant studies and
published and unpublished Australian and state government reports and research was undertaken. This included the Australian Longitudinal Study on Women’s Health, a study that began in 1996 and enrolled 40,000 women with the intention of periodically surveying them about their health over a 20 year period.

Examples of poor health outcomes for Australian women resulting from experiencing family and domestic violence are now provided:

- Between 1989 and 1998, over 57% of deaths in women resulting from homicide or violence were perpetrated by an intimate partner, with women being over five times more likely to be killed by an intimate partner than men (Mouzsos, 1999);

- In a study of patients attending a Brisbane Hospital Emergency Department, women reporting family and domestic violence were nine times more likely to report having harmed themselves or having recent thoughts of doing so, than women who had never experienced violence. (Roberts, et al 1997);

- Injuries to eyes, ears, head and neck as well as the breast and abdomen, especially during pregnancy, are common in women attending hospital for treatment. Where sexual violence is involved, bruising, tears and lacerations to the vaginal area and anus are common (Resnick et al, 1997; Campbell, 2002);

- Middle-aged women are significantly more likely to experience anxiety and depression (Parker & Lee, 2002), with one study of women attending GPs reporting a five-fold increased risk of depression (Hegart et al, 2004) even after other contributing factors, such as low income, were considered;

- The effects of violence can persist for many years. Women who have experienced violence in the past have lower rates of mental health problems than women reporting current family and domestic violence, but significantly higher rates than those who have never experienced this type of violence (Loxton et al, n.d);

- Women reporting family and domestic violence are more likely to use medication for depression and anxiety (Resnick et al, 1997);

- Some other psychiatric disorders (namely phobias, somatisation and dissociative disorders) are more common in women reporting family and domestic violence than those not affected (Roberts et. al, 1998);

- Women affected by family and domestic violence are more likely to have alcohol problems as well as to smoke and use non-prescription drugs, amphetamines and solvents (Quinlivan & Evans, 2001; Roberts et al, 1997, 1998);

- The use of tranquillisers, sleeping pills and anti-depressants is more common in women exposed to family and domestic violence than those who are not (Resnick, et al 1997; Campbell, 2002);

- Women reporting family and domestic violence are more likely to have an abnormal Pap smear and to report having a vaginal or endo-cervical infection (Quinlivan & Evans, 2001);
Young women who have been exposed to family and domestic violence are more likely to have an unplanned pregnancy, a termination or a miscarriage (Taft, 2002). They are slower to make contact with medical services for antenatal care than women who are not exposed to family and domestic violence and their babies are more likely to have a problem diagnosed after birth (Quinlivan & Evans, 2001).

Responses to Family and Domestic Violence – The Western Australian Context

Prior to the 1970s family and domestic violence in Western countries such as Australia was constructed largely as a psychological problem that resulted from individual male sadistic tendencies and/or masochistic tendencies of individual women (Snell et al, 1964; Gayford, 1979; Toch, 1969; Walker, 1977; Price and Armstrong, 1978). The move towards such psychological explanations of domestic violence began in the 1930s and focussed on the individual (Family Violence Professional Education Taskforce, 1992 pp. 97). During the 1960s and 1970s speculation on the psycho-dynamics of marital violence was a dominant theme and particular currency was given to the concept of ‘female masochism’. The notion that women got masochistic pleasure from being abused or were psychologically compelled to seek abuse, was also surmised to be the reason why they stayed. Further, the framing of these studies ignored the social context of women’s lives, and upheld the ideal of the family as an institution that provided love, protection and harmony where women’s central role was that of peacemaker. These explanations inevitably fostered a sense that the women themselves were to blame for the violence, and their subjective experience in the family and the socio-economic constraints on their options to leave a violence partner were consequently ignored.

In the 1970s feminists in Australia and other Western countries began constructing family and domestic violence as a social rather than a psychological problem. In 1974/5 Nardine Wimmin’s Refuge’ was opened by feminists in Perth and received the first funding for a women’s refuge in WA. Women’s refuges were, at this stage, and remained so until the early 1990’s, the main focus for services for women and children victims of family and domestic violence in Australia generally, and WA specifically. At first, however, refuges were funded primarily by donations and their staff were generally volunteers (Johnson, 1981).

The provision of shelter for women was not a new idea in WA; ‘Ave Maria’ had been operating by the Catholic Daughters of Charity in Perth since 1901; the Salvation Army had been providing shelter for women and children since 1973 (Saville, 1983; Scutt, 1983); and the Fremantle City Council had operated a women’s shelter known as “Warrawee” since 1971. These refuges, however, were usually more concerned with providing temporary accommodation for women and/or their children, until they could be reunited with their husbands and fathers, than with the broader issues that feminists connected with family and domestic violence (McFerren 1987).

In 1974 the Australian Labor Party (ALP) won government federally and funding for women’s refuges was hurriedly created under the umbrella of the Community Health Programme. Initially then, it was seen that the health sector had a vital role in providing funding for family and domestic violence services. The road for secure
funding for domestic violence services in WA was initially bumpy. Within months of
the creation of the Community Health Programme it was in doubt as the ALP was
defeated in the federal election. What was originally a 100% federally funded
programme became a cost-shared arrangement between the newly elected federal
government and the states. In WA the state government of the time was reluctant to
fund refuges and the administration of the programme was taken over by the Western
Australian Public Health Department (PHD). In the 1981/82 federal budget, funds
were no longer earmarked specifically for women’s refuges and it was left entirely to
the discretion of the state to fund them from the general health budget which, due in
part to the ‘recession’ at the time, was slashed.

After being inundate with community support for women’s refuges, the WA
government announced a 20% increase to women’s refuges in its 1981 state budget
and two new refuges in the Pilbara area of WA were set up. The PHD, however, still
expected refuges to raise funds and rely on volunteer work (McFerren 1987). The
1982 state budget saw another 20% increase in the women’s refuge budget.

In March 1983 an ALP Government was elected both federally and in WA. At both
levels of the government the ALP promised to increase funding for women’s refuges.
In terms of the federal government, this meant a return to direct funding.

In January 1985 the Supported Accommodation Assistance Programme (SAAP) was
introduced – a funding arrangement that remains current today. With the introduction
of this programme the department responsible for its administration was shifted from
the WA Health Department to the Department for Community Welfare (now
Department for Community Development), a move which was argued for by women’s
refuges in this state, presumably because of the on-going poor relationship between
the WA Health Department and representatives from women’s refuges and because
SAAP was responsible for funding a diverse range of supported accommodation
services apart from women’s refuges. The responsibility for funding of not only
women’s refuges but other domestic violence services in WA still remains in the
ambit of the Department for Community Development.

It was from the time that SAAP was introduced that services for victims of family and
domestic violence in WA began to change and diversify. In 1992 the WA state
government funded the establishment of various local domestic violence ‘action
groups’ across the Perth metropolitan area to have input into intervention points in
family and domestic violence. The main objective of these groups, which became
formalised under the umbrella of the Domestic Violence Council of Western Australia
(DVC) was to implement multi-agency, justice focussed, family and domestic
violence intervention projects in WA based on those operating in Duluth Minnesota,
USA and Hamilton, New Zealand (Fisher, 2001).

The genesis of a justice response to domestic violence in WA was abetted by a 1994
review of SAAP services. The recommendations of this report included, among
others, the rationalisation of services. A key point of this review and formalised in the
1996 report Working together: Action Plan on Family and Domestic Violence was the
notion that domestic violence services be ‘regionalised’ to ensure that services were
evenly spread across metropolitan Perth. The ‘regions’ referred to in the report
became operationalised as the state’s police regions. The government of the time
argued that in a justice response to domestic violence, the police role in arresting and
prosecuting offenders is central, and using police districts as community areas of responsibility would ensure an effective police presence in each region (Fisher, 2001).

Since 1996 the policy direction for family and domestic violence in WA has seen a ‘steady as she goes’ approach with an ‘across government’ ‘co-ordinated and integrated’ approach formalised in best practice models (Domestic Violence Prevention Unit, 2000). There are currently seventeen regional domestic violence committees operating throughout WA, comprising representatives of government and non-government agencies. According to the Family and Domestic Violence Unit (2004, p.17), the regional domestic violence committees are designed to achieve improved co-ordination and collaboration between all agencies involved in family and domestic violence on a regional level; and focus on increasing safety for individuals, families and communities through education and awareness of services providers, agencies and the community on family and domestic violence issues.

The prime department with responsibility for policy and responses to family and domestic violence in WA remains the Department for Community Development (DCD) through its Family and Domestic Violence Unit (Family and Domestic Violence Unit). The current state government strategic plan (Family and Domestic Violence Unit, 2004) gives priority to the safety of women and children; working in partnerships with the non-government sector, local government and the wider community; co-ordinating and integrating service delivery across government, and developing appropriate responses to family and domestic violence for Indigenous and women from culturally and linguistically diverse (CALD) communities. The Minister for Community Development Hon Sheila McHale MLA suggests that the plan is significant because it “means all relevant Ministers and government departments are working together under a single policy framework” (Family and Domestic Violence Unit, 2004, pp. v – vi). Whilst this policy framework exists, the extent to which it is given more than rhetorical significance, particularly in terms of health, is the subject of this report.

**Research Project Findings –Australia**

**Research Methodology**

This project comprises the Australian portion of an international research project examining women’s participation in family and domestic violence health policy development policy across five different countries – Canada, Bangladesh, Afghanistan, Thailand and Australia. Specifically the research was conducted by the Australian research team with the assistance of an interviewer and a transcriber in Western Australia, although across the country similar results would have be expected to be found albeit in differing ‘degrees’. That is, without pre-empting the findings section of this report, the prime focus for family and domestic violence policy across all Australian states is the legal system, with health taking a secondary role.

**Data Collection**

Qualitative research has many precedents in research on family and domestic violence (see for example Buchbinder and Winterstein, 2003; Best, 2002; Nicolaïdis, 2002) and allows for the identification of constructs that are salient to the participating
individuals. This qualitative research was undertaken specifically using structured interviews with two interviewers sharing responsibility for their undertaking – one interviewer was a member of the Australian research team. Both interviewers had similar techniques which ensured seamless data from their respective interviews.

Participants and Recruitment

Participants for the study comprised 30 individuals identified by the Australian research team as being stakeholders in the area of family and domestic violence and/or health policy in WA. Specifically participants were drawn from three key ‘areas of concern’ for this study, namely the ‘health policy community’, the ‘family and domestic violence prevention community’ and ‘other interested stakeholders’, that is, those that have an interest in, but are not directly involved in, family and domestic violence. A full list of participants and their affiliations in terms of these areas of concern are attached as ‘Appendix A’.

To facilitate access to a wide range of participants that would add dimension and depth to the study, ‘snowballing’ as a recruitment technique was also used. At the conclusion of each interview, the participant was asked who s/he thought we should also ask to participate in the study.

Participants were generally very keen to participate in the study. Of the 38 individuals/agencies approached to participate, 30 agreed to do so. Three of the eight who did not participate were, however, keen to do so, but circumstances were such that this was not possible: two of the three were ill over an extended period and so unavailable within our timeframe, and the other, a group involved in disaster relief, had to prioritise those activities after the Boxing Day, 2004 tsunami in Indonesia. Another three of the eight who declined to participate did not consider that they had any connection to the issue of family and domestic violence and, hence, would not be able to add to the study. Only two agencies did not want to participate, one giving no reason and the other, an Indigenous service, declining to participate citing a belief that too many studies are undertaken on Indigenous people.

Through the two recruitment methods described above, we were able to interview our total of 30 participants and, thus, be provided with very thick and rich description of the issue being investigated.

Data Analysis

Data collection and data analysis occurred simultaneously for this project. Individual interviews with the 30 participants were transcribed verbatim by a single transcriber and imported into QSR N6 computer-based qualitative data analysis programme. ‘Base Nodes’ were created in N6 to facilitate coding for the type of agency that the participant represented (ie, state, Non Government Organisation (NGO), Academic Institution), the agency classification (in terms of health policy community, family and domestic violence prevention community, and other interested stakeholders) and the individual’s role within their respective agency. From that point onward, data were coded to nodes as themes/issues arose from within the data.
Once initial coding of all the interviews was complete, the nodes were then able to be interrogated to enable the researchers examine the types of links that existed between and within the various agencies, how each individual/agency conceptualised family and domestic violence, the extent to which women were/should be involved in decisions around policy and service provision and the cleavages that exist within and between the various communities. The researchers were also able to ask specific questions of the data. For example, Who does the Health Policy community identify as leaders in family and domestic violence issues? And do these differ from the family and domestic violence prevention community? What is the extent of links and networks between the health policy community and the family and domestic violence community? What is the extent of links and networks within the health policy community? Is there a link between constructing domestic violence in terms of its criminality and lower levels of inter-sectorial collaboration?

The findings of this interrogation of the data constitute this research report.

**Ethical Considerations**

Ethical approval was given by the Human Research Ethics Committee of Edith Cowan University to undertake the study. Information regarding the purpose of the study was given to the participant and his/her written consent to participate in the study was obtained, prior to the interview commencing. All participants were guaranteed confidentiality and anonymity and were assured they could withdraw from the study at any time, or not answer any question asked that they felt uncomfortable answering.

**Findings and Discussion**

The following sections of this report document and describe the findings of the research.

**Understandings of Family and Domestic Violence**

There is near universal recognition among all participants in this study, whether they are members of the health policy community, the domestic violence community, or other interested stakeholders, that behaviours constituting family and domestic violence are multifaceted and extend beyond physical violence.

Well violence against women can take many forms…but the violence can be emotional, physical, financial and verbal. (Women’s Law Centre).

Violence against women is an act of, of, abuse. So violence in all it’s different forms, like emotional, psychological, spiritual, financial, abuse to a woman. (Mirrabooka Regional Domestic Violence Committee).

The understanding of family and domestic violence as multifaceted is formalised at state level in policy documents relating to the issue.

Domestic violence is considered to be behaviour, which results in physical, sexual and/or psychological damage, forced social isolation, economic...
deprivation, or behaviour which causes the victim to live in fear (Family and Domestic Violence Unit, 2004, pp. 5).

The exception to this understanding is from the WA Police Service who, despite recognising that family and domestic violence occurs in a broader context, in terms of its mandate, foregrounds only its criminal aspects.

From a policing point of view we’d, we see that any form of physical assault in particular is what we would term… the higher level of domestic violence but it falls much broader in that in relation to other types of crimes that have, that are perpetrated in the home or in domestic relationships that, that may mean that violence is occurring. So it may be damage or it may be injury to pets or killing of pets. So the violence itself is not just the physical assault. (WA Police Service).

Most participants were able to recognise issues of power and control as central to domestic violence.

So to me it’s [family and domestic violence] anything to do which is about power and control over someone else and using any strategy to get them to do what you want to do. (Joondalup Regional Domestic Violence Committee).

It’s [family and domestic violence] based on an issue of power and control. A desire to control the lives and actions and circumstances of their partner and children. (Women’s Refuge).

Very few respondents, however, actually placed domestic violence in a feminist context. That is, most did not articulate family and domestic violence as a phenomenon resulting from patriarchal social relations. Rather, they were ambivalent about its relationship to the social structure or simply conceptualised it in terms of its multifaceted nature.

Indeed, this is most overt in the case of indigenous West Australians among whom the term ‘family violence’ is preferred. The term family violence “encapsulates not only the extended nature of indigenous families, but also the context and range of violence in indigenous communities” (Gordon, 2002, p. 518). This sentiment is echoed among indigenous participants in this study.

[In the] aborigine community we see domestic violence more related to the broader term of family violence because it, it involves, you know, like extended families and different elements of feuding and a whole range of things. So it’s[domestic violence] slightly, a little bit, different I think to what we call family violence. (Indigenous health service)

In light of the indigenous understanding of the nature of domestic violence, in this report the issue is termed ‘family and domestic violence’ rather than domestic violence per se. This terminology is also in line with that used routinely in the community in WA and that referred to in official policy documents. The use of this term, however, should not and does not obscure the fact that women and children including indigenous women and children bear the brunt of family and domestic violence.
Who are the ‘leaders’ in family and domestic violence in Western Australia?

The participants in this study reflected on many individuals and agencies that they considered to be ‘leaders’ in the area of family and domestic violence. Mentioned were state government departments, namely the WA Police Service, DCD, along with the Family and Domestic Violence Unit (FDVU), the unit in that department with specific responsibility for family and domestic violence), the Office for Women’s Policy (OWP), Department of Justice (DOJ) including its Family Violence Unit, WA Health Department, Office of Multicultural Interests, and the WA Education Department.

At the level of non-government agencies that provide direct services to those affected by family and domestic violence many more potential ‘leaders’ were identified: Legal Aid Commission of WA, women’s refuges, Armadale Domestic Violence Intervention Project (ADVIP) and Domestic Violence Advocacy and Support Central (DVAS Central). Agencies that provide services to perpetrators of family and domestic violence were also identified: Kin Way, Centrecare, Relationships Australia, Anglicare and indigenous men’s programs. Additionally, services were identified whose clientele are affected by family and domestic violence but not their primary presentation: women’s health care houses, Council of Single Women and Mothers, Sisters on the Inside and community legal services. At the level of co-ordination of services, Women’s Council for Family and Domestic Violence Services (Women’s Council) the various regional family and domestic violence prevention committees, WA Council of Social Services (WACOSS), Women’s Emergency Services Network (Westnet) and specialist indigenous services such as the National Network of Indigenous Women’s Legal Services were identified, as well as more global organisations such as Amnesty International.

To break this ‘list’ down and give it some kind of context, those who the three ‘groups’ within this study (ie, ‘health policy community’, ‘family and domestic violence community’, and ‘other interested stakeholders’) identified as ‘leaders’ will be discussed in broad terms.

Health Policy Community

Within the health policy community, the list of ‘leaders’ on domestic violence issues was largely confined to DCD, the Women’s Council and the WA Police Service.

Women’s refuge group (now the Women’s Council1). There’s no question that they are the leaders and have been the leaders for decades and they remain the leaders. It’s as simple as that……surprisingly the Police Service is demonstrating some leadership. (WA Health Department).

Well, the women’s refuge group (now the Women’s Council) should have to be the key player…The Family and Domestic Violence Unit as the, as part of Department of (sic) Community Development have been obviously leaders now, but the initial leadership came from the women’s refuge movement. (WA Health Department).

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1 In 2004 the Women’s Refuge Group of WA changed its name to Women’s Council for Family and Domestic Violence Services. The Women’s Refuge Group has a history dating back to the 1970s and, as such, it is still commonly referred to as the Women’s Refuge Group or WRG.
I would say probably the Department for Community Development. Both service delivery but also they have a Family and Domestic Violence Unit which is the lead party for that. (Women’s & Children’s Services, WA Health Department).

It is interesting to note that participants in the study from the WA Health Department, including a participant in a senior policy position, did not see the Health Department as a lead agency as far as family and domestic violence issues are concerned.

**Family and Domestic Violence Community**

Agencies situated outside of the health policy community identified leaders in family and domestic violence as coming from a more diverse array of agencies/backgrounds reflecting their belief that the non-government sector is a vital component of the policy response to family and domestic violence.

You would have to say the Family Violence Unit, I think [Office of] Women’s Policy have commitment to violence against women. And DCD obviously because they fund a lot of the service(s)…[so] probably more so around the funding and service provision side of things. And non-government would be …..Women’s Council for Domestic and Family Violence [services] and then a whole other range of stakeholders such as regional committees…. and women’s health care houses have also been really active in taking up on the issue. (Women’s Council)

Well the primary ones for us would be, if we start in the community leaders, it would be the Women’s Council on (sic) Family and Domestic Violence Services. There are other service provider agencies so you would have service providers of repute, Centrecare, Anglicare, all the women’s refuges have presence. (FDVU)

There’s a couple of the regional domestic violence committees. Particularly at the moment, Fremantle, Rockingham and Armadale…I believe are the most innovative. (DVAS Central)

Certainly the NGO’s are I think one of the most influential groups. (Legal Aid Commission of WA).

DVAS, that the Domestic Violence Advocacy Centre which is excellent …..and the Domestic Violence Legal Aid Unit. (Women’s Refuge).

**Other Interested Stakeholders**

Oh well the women’s refuge women, well what used to be the Women’s Refuge Group. The Women’s Council on (sic) family and domestic violence. I guess theoretically the government unit with the mandate to address this should be seen there but often it needs some prodding and that is the Family and Domestic Violence Unit. Police also are fairly active in this area as is Legal Aid Commission. The Community Legal Services, many of those are now involved in the issue of domestic violence. (Family and Domestic Violence Researcher).
I think the, the Regional Domestic Violence Groups are actually very influential or potentially are very influential. (Academic Researcher).

I mean I guess the Women’s Refuge Group (now Women’s Council) would be one… I think Community Development has a very high profile… I think the, and again it’s become more high profile of late, would be the Police… you could, you could look at all of the different counselling agencies for other specific programmes like CentreCare and Relationships Australia… Kinway. (Crisis Care).

What is apparent from the analysis of data regarding the identification of ‘leaders’ around family and domestic violence issues in WA is that as you move beyond the health policy community, reflective of ongoing collaboration and networking, there is a recognition that many agencies/individuals are influential and all have a role to play – the philosophy of integrated service delivery. The limited number of potential ‘leaders’ identified by the health policy community is reflective of two things: the secondary importance given to the issue of family and domestic violence by the WA Health Department and the minimal linkages between the health policy community and other stakeholders. Both these issues are discussed in detail below.

**Are ‘Core’ Lead Agencies Identified?**

The ‘core’ lead agencies, that is, agencies that were identified in common across the three participant subgroups as ‘leaders’ in family and domestic violence were the Women’s Council, DCD and FDVU, the WA Police Service and Legal Aid Commission of WA. What is of particular interest for the purposes of this project is that neither the WA Health Department nor specialist indigenous agencies were identified uniformly as leaders in the area.

**Health Sector and Family and Domestic Violence Policy Formulation, the WA Context**

In light of health not being seen as a leader in the area of family and domestic violence in WA, the task then becomes one which examines factors that impact its secondary position. These factors are discussed in terms of ‘historical factors’, ‘linkages between family and domestic violence community and the health sector’, ‘linkages within the health sector’, ‘disagreement about the fit of family and domestic violence and WA Health Department mandate’, and ‘family and domestic violence and the medical model’.

**Historical Factors**

Although records show that, throughout history, men have abused their female partners, only since the 1970s has ‘domestic violence’ been represented as a social problem in Western countries including Australia. Prior to this time most people assumed that violence against female partners was rare, rarely serious and, curiously, somehow caused by the women themselves (Snell et al, 1964; Gayford, 1979; Walker, 1977; Price and Armstrong, 1978). As discussed in the introductory section of this report, family and domestic violence in Australia generally, and WA specifically was...
identified as a social problem by feminists in the women’s refuge movement in the
1970s who constructed the issue as resulting from patriarchal social relations. Refuges
for women and children escaping the violence was the main service for them in WA
until the late 1980s/1990s.

By 1977 nine women’s refuges were operating in WA and given the situation
regarding meagre and unreliable funding, a collective constituting these nine
individual refuges was formed:

The Women’s Refuge Group which is what we were previously called, started
in 1977 and it was started so that there was nine refuges at that time, they came
together and they wanted their voice to be heard in a unifying manner and for
issues to be promoted in that way. In, in those days the issue wasn’t clearly on
the agenda. There were very few services and very little acknowledgement that
even the issue was genuine as such….So from the 1970s to really the 1990s, it
was that era of breaking the silence and getting some service responses up that
were funded and actually recognised at a state political level such as Women’s
refuges. (Women’s Council).

In the WA context then, although initial funding for women’s refuges was provided
through the Health Department, via either the Community Health Programme, or the
WA Public Health Department, the issue was largely taken up and ‘championed’
through the Women’s Refuge Movement. These early feminist women were also
wanting to detach the issue from its earlier construction as an individual issue for
individual women, resulting somehow from personality deficit.

Data from this study suggests that this separation of family and domestic violence and
health is still apparent contemporarily:

I think it’s the way say women’s issues have been approached, like historically,
has actually been in quite a divided way. Like, the issues have all been
separated. So you have the domestic violence, kind of, you know area, our area
[homelessness] and then, you know, like women’s health centres…..and I don’t
actually feel there’s a lot of talking between all the different groups around
the….different issues that are coming up or even between the different
population groups (Ruah Home Support Services).

**Linkages Between Family and Domestic Violence Community And The
Health Sector**

According to a representative from the FDVU ‘health is a difficult beast’. By this s/he
meant that the department is large and multi-sectorial. With this caution in mind, this
section examines linkages between the family and domestic violence community and
the health sector at two levels – grass roots level and strategic policy level.

(a) Grass Roots Level

The level that most of the interaction between the family and domestic violence
community and the health sector occurs at ‘grass roots’ level. That is, networks and

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2 The Women’s Refuge Movement is the name given, in Australia, to movements such as the ‘Battered
Women’s Movement’ in the USA and the ‘Shelter Movement’ in the UK.
relationships have developed at individual agency level with these relationships, at times being particularly strong.

We directly interact with individual people in the health sector through women and children needing direct medical assistance. So the local doctors, the local hospital, the local mental health service, so in that sense we would have one on relationships with individual health providers. We don’t sit on any reference group or policy advisory group or steering group directly related to the Health Department. (Women’s Refuge).

Women here have health care needs…and their children do as well. You know, we have a good relationship with our local GP surgery. We have a health nurse that visits, you know, here in terms of the kids. (Women’s Refuge).

Actually we work quite closely with the Women’s Health Service although I tend to think of that as an NGO rather than the health sector. (Interviewer: Do you interact with any health policy makers? ) No, not really (DVAS Central).

In addition to relationships between individual agencies, representatives from the community health sections of the WA Health Department are often members of the various family and domestic violence regional committees (Mirrabooka, Joondalup Regional Family and Domestic Violence Committees). These representatives, however, are not in a position to be able to influence policy direction within the WA Health Department, but represent, on behalf of the department, the various health service providers.

Whilst there is ongoing networking at grass roots level, relationships between the family and domestic violence community and the health sector at policy level is minimal.

(b) Strategic Policy Level

Participants in this research at the WA Health Department clearly articulate the need for health to be networked in with other agencies in WA that address family and domestic violence at a policy input level. As one WA Health Department participant notes:

Our primary responsibility is the treatment of injury and the preservation of health and life. So that would be the…unique, if you like, area of service that this department is responsible for and the more broad areas of responsibility obviously are the support, social support and the secondary prevention of, in other words, of further episodes of violence and our role may not be that we are able to achieve that alone since we are after all the health system. So we need to have the networks with services [that] can. (WA Health Department).

The reality appears to be however, that although there is a clear articulation of the need for networks, there is minimal networking between health and the DV community in general.

Well we [Women’s Council and Health Department] probably don’t interact as well as we should. I remember [a couple of years ago] speaking to someone who had been involved in writing it [a report on family and domestic violence]}
and they didn’t want the Health Department to get so closely involved with the issue…So yes it’s, I don’t think they want to make those links and we probably haven’t been as successful as we’d like to be with making those links between women’s health and domestic violence. (Women’s Council).

It appears from this research that the FDVU is the ‘lynch pin’ that links the two sectors and ensures ongoing dialogue.

**FDVU as a ‘lynch pin’**

Despite the limited nature of the relationships between the health policy community and the family and domestic violence community, the FDVU ‘bridges the gap’ somewhat between the two to facilitate ongoing discussion and engagement. Indeed, links between the FDVU and the WA Health Department are reported by the FDVU as good:

[Our relationship is] Absolutely [fine] on a number of levels. In terms of our work across government, health is critically involved there …we’ve got strategic alliances with the health sector around things like screening. So we’re working with them in developing some screening tools so that people, that domestic violence is detected. (FDVU).

The nature of the relationship however, is akin to a ‘one-way street’. The FDVU is forging networks within the health sector, yet those in the health sector with an interest in family and domestic violence don’t appear to be actively networking with members of the family and domestic violence community as evidenced by the FDVU being unaware of who else it is they need to network with:

The people we talk to are the people we’ve identified [emphasis added] that we need to have a relationship with and it’s strong and it’s collaborative and it’s co-operative. But there would be other parts of health that we have no relationship with and we don’t know. (FDVU).

This insularity is further highlighted. A Senior Policy Officer in the WA Health Department suggests that, as far as a family and domestic violence health policy formulation is concerned s/he would consult internally:

Well if you’re talking health policy then you’re talking pretty internally. I know that, in a fashion, all policy, the thing is to say you’ll talk to every single living soul, you’ve been with the pulse of the universe, but realistically, I’ll talk to other health people first. This is a health system it’s trying to do its job, so they’re the first ones that I’d want in the room…[If you’ve] scanned the whole health system [and] found out what the providers….would like to be able to do within the orbit of their professional practice….that’s what we’re [health system] working on. (WA Health Department).

**Linkages Within the Health Sector**

Not only are there minimal linkages between the health sector and the family and domestic violence community at a policy level, but this scenario is repeated at an intra-departmental level.
As the following participant indicates, even though s/he is in close contact with the departmental policy section and has family and domestic violence as his/her sole responsibility, s/he has not been privy to any policy making process.

I’ve not been able to be a part of the policy making. … The policy now on family and domestic violence that’s being, formulated, I haven’t seen nor have I been involved with it, even thought I’m in frequent contact with the person who’s running the policies… I have not been invited to be part of it [and] I would be the only person whose position in the Department of Health in Western Australia is solely concerned with family and domestic violence. (WA Health Department Project Officer).

Disagreement About the ‘Fit’ of Family and Domestic Violence and WA Health Department Mandate

Findings of this research highlight two diametrically opposed views regarding the ‘fit’ of family and domestic violence and the mandate of the WA Health Department from within the department. One view suggests that because the provision of services such as hospitals provides a place for victims of family and domestic violence to go to be treated for their injuries, there is a ‘perfect’ fit between the two:

It’s [the mandate is] the preservation of life and health. People who are injured or damaged in some way through accident, injury or whatever… it’s [a] well established part of community knowledge that, you know, whatever your source of injury, you to go to hospital or other parts of the health system. (WA Health Department).

In the above quote, the view espoused by a respondent from a policy position within the WA Health Department may further explain why, beyond the provision of hospital and other medical services, there is little will within the WA Health Department to become involved in the issue of family and domestic violence. That is, its mandated obligations to victims of family and domestic violence are fulfilled by provision of these services.

The opposing view, however, from a respondent who has family and domestic violence as his/her sole responsibility, suggests that the mandate of the Department and family and domestic violence doesn’t fit “particularly well” and, furthermore, although rhetorically the mandate is there to act, in practice

It’s [family and domestic violence] only been paid lip service to. It’s not been addressed. It’s not part of mandatory reporting. It’s not part of key performance indicators.

Further,

There is no compulsion for the health services to have any policy [on family and domestic violence] so although there is a policy there and although the statement to the Family and Domestic Violence Unit was that Department of Health staff are obliged, in reality most Department of Health staff don’t even know that the policies exist, that the protocols exist, therefore they don’t know what to do about it. (WA Health Department).
This ambivalence about the mandate of the WA Health Department as regards family and domestic violence is echoed in perceptions in the family and domestic violence community. At this level there is also doubt as to the will of the WA Health Department to be proactive on the issue.

What they [WA Health Department] really do is say “No that’s not our issue, it’s, it’s, DCD’s issue, it’s a family issue and it should be resolved within the family and it’s just about dysfunctional families. Or it’s a women’s issue”. So they’re really the two levels of response. Or it’s now saying “It’s a police issue to remove the perpetrator from the home or, or arrest him on the spot”. But health, if you bring it up as a health issue, no they [WA Health Department] don’t really want to know that…….”Have you seen anyone in the Health Department that is actually open to the idea? [developing a women’s domestic violence health policy] Would there be anyone within the Health Department? Not really. (Women’s Council).

**Family and Domestic Violence and the Medical Model**

The extent of the involvement of the WA Department of Health in services for victims of family and domestic violence is through the provision of medical treatment, the funding of women’s health and information services and specialised sexual assault resource centres (Family and Domestic Violence Unit, 2004). Individual health professionals do provide referrals to support services for victims, but being individual in nature, it tends to be ad hoc. That is, the service a woman receives is largely a result of an individual decision by an individual health professional.

Publicly funded provision of medical treatment for victims of family and domestic violence is largely through emergency departments at public hospitals. These hospitals by their very nature reflect a biomedical model of health. There is a wide disparity, however, between the biomedical model which looks for causal relationships and defined parameters in terms of amelioration of injuries, and the issue of family and domestic violence with current service models emphasising victim empowerment and choice. As such, there is a mis-match between the issue (family and domestic violence) and the response (biomedicine). This mis-match may, in part, explain the reluctance of the health sector to respond to the issue.

The health system is one which is based on, very clear step by step protocols and processes that you follow. So if the person comes in with X wrong with them, then you do Y then you refer to P and they have two Zed’s done to them and then they get and X and take it home and, and it’s not like that with domestic violence……even if there is a disclosure, even if there is a very obvious series of injuries and a history and disclosure about violence from victims, they have a choice about what they want to do about it and while it may seem obvious to a person they’re disclosing to, that they should do this or do that and do it immediately, that may not be that person’s choice. So there is still a whole amount of work to be done across the health system about that area of choice (WA Health Department).

This being said, there are ‘pockets’ within the health sector that have made attempts at addressing the issue of family and domestic violence, but these are ad hoc and not
governed by a directive or policy to do so. One good example of this in the WA context is within the Women’s and Children’s health services.

We have representatives [domestic violence liaison officers] within our two [women’s and children’s] hospitals. They have meetings biannually in Perth where they then get together will all the other hospital liaison people form around the state and they update each other and, you know, on things that are happening. We also have had meetings with the Department for Community Development with their Family and Domestic Violence unit around policies and responses to family and domestic violence. We’re currently in the throes of actually putting together a project around that specific task within the hospital. So hopefully that will sort of happen at that level. (Women’s & Children’s Services WA Health Department).

It is probably not so surprising that women’s and children’s health is at the forefront of developing policies and responding to the issue of family and domestic violence as there is a voluminous literature about the impact of pregnancy on increasing family and domestic violence (Frost, 1999; Taft, et al, 2004; Martin, et al, 2004; Lutz, 2005; Grossman, 2004). Additionally worldwide, children’s health nurses have been at the forefront of screening measures and other interventions in the issue of family and domestic violence (see for example Frost, 1999; Henderson, 2001; Olds et al, 2004).

In the general tertiary health sector in WA, however, advances in having family and domestic violence considered an issue for health professionals to respond in line with broader policy have been less promising. In 1998 The WA Health Department developed an initiative whereby publicly funded hospitals in WA were give financial incentives to assist them to develop and implement protocols for intervention in, and management of, family and domestic violence. This scheme, however, is not mandatory and neither governed by policy nor directive. The uptake rate of the initiative has been poor to date:

my role is to actually go around or to contact hospitals and ask them would they like to set up policies and protocols for which we give them a two thousand dollar incentive grant… there are some twenty four hospitals across the State who in, in the last five or six years have actually taken up that offer. We have eighty-four hospitals across the State, so there is still a lot to go. (WA Health Department).

The Policy Response to Family and Domestic Violence

Despite widespread understanding that family and domestic violence is multifaceted, the policy response in a WA context has been largely focused on the legal system both in its civil and criminal jurisdictions as exemplified above (page 7) by the WA Police Service quote about the nature of family and domestic violence.

Using the criminal justice system for social policy in terms of family and domestic violence sits nicely with the immediate political reality for the state government of being ‘seen to be doing something’ in terms of family and domestic violence. Through intervention in family and domestic violence via the legal system, the state can argue that it is fulfilling its obligations to uphold the rights of women affected by violence.
In the second half of the last decade of the 20th century there were a number of community education campaigns in WA around the issue of family and domestic violence that targeted family and domestic violence in its physical guise. The most prominent campaign was perhaps the “Domestic Violence is a Crime” campaign which highlighted the physical nature of family and domestic violence and used graphic images of frightened children crying and cowering in shadowy rooms, and of the bruised bodies of women to illustrate those who have experienced ‘real’ domestic violence. This campaign was accompanied by research into family and domestic violence in WA that attempted to estimate its incidence and prevalence (Crime Research Centre UWA, 1995) through the use of police statistics.

At the same time, research was being published internationally around co-ordinated and integrated responses to family and domestic violence that centred the legal system (see for example Pence and Paymar, 1993; Edleson, 1991; Eldleson and Tolman, 1992; Syers and Edleson, 1992; Domestic Violence Prevention Unit, 2000; Minnesota Center against Violence and Abuse, 2001) and pushes for a cultural change from police departments in terms of responding to family and domestic violence incidences. Interventions included mandatory arrest (Williams and Hawkins, 1992;) and, in the civil jurisdiction the use of violence restraining orders (Family and Domestic Violence Taskforce, 1996; Graycar and Morgan, 1990).

At a local level a much heralded initiative in terms of family and domestic violence was the Joondalup Family Violence Court. This specialist court with its own magistrate, personnel and victim support services is stated to be:

A unique way of dealing with perpetrators and victims of domestic violence...[It’s] a holistic approach in that victims are supported [with counselling] through the process as well as the perpetrators [through court diversion perpetrator programmes] (Joondalup Family Violence Court).

The success of this court in responding to family and domestic violence revolves largely around the fact that:

We have eighty percent of the guys actually complete the programme. (Joondalup Family Violence Court).

This is despite an abundance of literature which is equivocal about the effect of family and domestic violence perpetrator programmes on safety for victims (Dobash et al, 1999; Gondolf, 1997).

All this notwithstanding, a legal response to family and domestic violence is the centrepiece of interventions in WA. With the centring of the legal system, the role of the WA police has become more prominent to the extent that now, analysis of data from this research identifies the WA police service as a leader in the area.

**Women’s Involvement in Health Service Development and Family and Domestic Violence Health Policy Formulation**

Analysis of the data for this study suggest that the family and domestic violence community does not consider there is a strong will and commitment to the
consultation process among government departments charged with the responsibilities of policy formulation and service development.

The main thing…is to ensure that the people that are developing the policy have a commitment to involving people. I think that often consultation processes don’t really, like if you have to consult, you do…..it’s often more about that, rather than having a commitment to doing meaningful consultation and making the results of those consultations meaningful in the policy. (DVAS Central).

The consultation process is addressed in these departments rhetorically, but in practice, many see that there are few tangible outcomes for stakeholders.

People get consulted to death and nothing ever changes. (DVAS Central).

There is even the view that because those who are involved in the issue of family and domestic violence are largely women, there is no need to consult other women outside of the family and domestic violence community:

Well they [women] are involved because it’s pretty well driven by, been driven by the Women’s Refuge Movement, the Women’s Movement, the Women’s Health Care Movements. The Community Legal Centres. Community work basically is eighty-five percent of the staff are women. The management committees about eighty-five, ninety-five percent are women…When you start analysing who’s involved. The jobs, even in Police which end up domestic violence increasingly becoming the women. Even the aboriginal police liaison officers increasingly becoming the women. So it’s like, the women end up in the social services soft side of things and then men end up in the economic admin CEO capacity. So the women do drive it [policy formulation]. (Joondalup Regional Domestic Violence Committee).

The question then becomes, who should be involved in service development and policy formulation and is it the domain of women in general, or are women involved by virtue of special expertise. Results of this study suggest that there is a different mind set regarding the extent to which consultation is appropriate. The extent depends on whether the outcome is policy or service provision and so, each scenario is examined separately.

Consultation for Service Provision

In terms of consultation for service provision, there is the belief that wider consultation is appropriate and women - as women - have access to knowledge that is required to articulate what services should be provided. That is, the articulation of appropriate services in a hypothetical health service is not dependant on access to specific professional knowledge or expertise.

There needs to be a number of ways for people to have input (Department of Premier and Cabinet).

You have to actually have a community development process where you have someone designated…They go and talk to [all kinds of] groups] If you don’t go down to their space, the occasional person you get to come along is probably the
person who’s gone to everything like this for the last fifteen years. (Joondalup Regional Domestic Violence Committee).

Even the WA Health Department is suggesting that consultation for development of a health service involves hearing the voices of women who would be accessing the service:

Well I think I’d probably actually go local to start with. The stake holders really are … not people who have got an opinion. They’re people who are personally and profoundly and long term affected by what it is that’s proposed. So I’d start locally with whoever that, whoever’s it’s intended to be for. (WA Health Department).

This position is in stark contrast to the Department’s earlier position regarding internal consultation for family and domestic violence health policy (page 18) and provides a poignant example of the distinction the WA Health Department sees between service provision and policy formulation.

This notwithstanding, it is largely through existing women’s networks that participants in the consultation process are reached.

We could…go to our agencies and talk about this concept [new health service] and then they could then go out and talk to their clients about what services they think would be involved in it. And I also think that the agency workers would have a good idea of what is needed through their work with clients (Mirrabooka Domestic Violence Regional Committee).

I’d look at existing, existing consultancy strategies. So there is the Women’s Advisory Council. So they can give you a high level of input. We have an Indigenous Women’s Congress, the government do, so we could look at that. We’d talk to some of the established peak bodies, so the Women’s Council, the Women’s Health Centre have centres [and] have a peak or representative structure. So I’d talk to those. (FDVU).

So, the input of women who have been affected by family and domestic violence and/or women in general is largely in the form of indirect representation by providers of relevant services. This is particularly true for indigenous and CALD women who are seen to need specialised services and the expertise for these services lies in the networks of indigenous and CALD women’s service providers.

You’d have to do something specific around CALD and indigenous women. I think that would need to be guided by their various peak bodies and groups. (Pat Giles Centre).

Consultation for Family and Domestic Violence Health Policy

Analysis of the data suggest that there is disquiet among the family and domestic violence community about the limited consultation that the WA Health Department undertakes in terms of policy formulation:
I feel that they [policy makers] don’t often take advice from outsiders and if they do, they’re from government agencies (Mirrabooka Regional Domestic Violence Committee).

As noted above, (page 18) the feelings of this representative of the Mirrabooka Regional Domestic Violence Committee is echoed in the position of the WA Health Department in terms of policy consultation, that is, it is largely an internal (health) matter. It could be argued that WA Health Department sees the area of policy formulation as a ‘specialist’ area and, as such requires input from those who ‘know’ policy. That is, those who, by virtue of their position and access to specialised knowledge and language are able to speak with authority. The everyday knowledges of women, who may have been victims of family and domestic violence are, thus, rendered secondary to this professional knowledge.

**Conclusion**

Family and domestic violence policy in WA centres the legal system and, as such health plays a secondary role. This being said, there appears to be little will within the WA Health Department to alter this situation. The issue of family and domestic violence is not seen as a priority within the department with only one position in the department having family and domestic violence as its sole focus. The person occupying this position, however, is not involved with any policy processes, despite being recognised as having responsibility for the issue.

Responsibility for family and domestic violence health policy formulation rests with the Gender, Child and Community Health section of the WA Health Department, but policy officers within this section appear insular both in respect of internal consultation, just described, and also in terms of links and networks with the wider family and domestic violence prevention community. Indeed, the major links between the two occurs at grass roots level, that is, links between individual agencies at the coalface of service provision.

The notion of networking and forging links to facilitate collaboration in terms of family and domestic violence policy, however, is, recognised within the health policy community. This being said, the commitment appears to be largely rhetorical. The WA Health Department recognises the leadership role taken by the Women’s Council in terms of family and domestic violence issues, yet there are very poor links between the two. The FDVU appears to be the lynch pin that connects the two ‘communities’ together, but the ongoing process of network maintaining and fostering, and collaboration is largely ‘one-way’ with the WA Health Department not seeking out new networks as does the FDVU.

In terms of women’s involvement in family and domestic violence health policy formulation, the health policy community considers this largely a matter to be dealt with within the WA Health Department with input from other individuals/agencies who ‘know policy’ – other government departments. The voices of individual women, thus become lost, even if they are advocated for through agencies and agency staff with whom they come in contact.

The mindset is somewhat different when it comes to service development. In such instances, wider consultation is considered desirable by the health policy community.
and, as such, the voices of women for whom the service is intended become more valued.

Given the poor health outcomes for women who have been victims of family and domestic violence and the WA Health Department’s rhetorical commitment to addressing the issue in policy documents, it is evident from findings of this study that two issues need to be addressed. Firstly, there needs to be a commitment that extends beyond rhetorical to address the issue in terms of its health dimension and, secondly, to facilitate this, effective links and networks must be forged and fostered between the family and domestic violence prevention community and the health policy community.
Bibliography


Appendix A

List of Research Participants

1. Health Policy Community
   - Gender, Child and Community Health, WA Health Department
   - Family and Domestic Violence Protocols Project Officer, WA Health Department
   - Women’s and Children’s Health Service – WA Health Department

2. Family and Domestic Violence Prevention Community
   - Child Protection and Family Violence Unit – WA Police Service
   - Women’s Council for Family and Domestic Violence Services
   - Pat Giles Centre
   - Starrick Services
   - Joondalup Domestic Violence Regional Committee
   - Family and Domestic Violence Unit – Department for Community Development
   - Domestic Violence Advocacy and Support, Central.
   - Legal Aid Commission of WA – Domestic Violence Unit
   - Salvation Army Women’s Refuge
   - Wyn Carr House
   - Ruah Women’s Refuge
   - Department of Justice
   - Crisis Care
   - Joondalup Victim Support
   - Men’s Domestic Violence Helpline
   - Mirrabooka Regional Domestic Violence Committee

3. Other Stakeholders
   - Derbly Yerrigan
   - Curtin University Department of Social Work
   - Office of Women’s Policy
   - Yahning Aboriginal Service
   - Multicultural Women’s Advocacy Service
   - Homicide Prevention Group
   - Ruah Tenancy Service
   - Edith Cowan University – Youth Work
   - Cultural Diversity Advisor – Department for Community Development
   - Women’s Law Centre
   - Gordon Inquiry Secretariat – Department of Premier and Cabinet