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'Health's a difficult beast': The interrelationships between domestic violence, women's health and the health sector An Australian case study

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Abstract

This paper reports on the Australian component of a five nation study undertaken in Australia, Canada, Thailand, Bangladesh and Afghanistan examining policy networks that address women's health and domestic violence. It examines the relationship between health and domestic violence in Western Australia and analyses the secondary role assumed by health. The study adopted a qualitative research paradigm and semi-structured interviews. Snowball sampling was used to identify relevant and significant stakeholders and resulted in a final sample of 30 individuals representing three key areas: the 'health policy community', the 'domestic violence prevention community' and 'other interested stakeholders', that is, those who have an interest in, but who are not involved in, domestic violence prevention work. Results suggest that the secondary positioning of health is associated with the historical 'championing' of the issue in the women's movement; limited linkages between the health policy community and the domestic violence prevention community and within the health policy community itself; the 'fit' between domestic violence and the Western Australian Health Department mandate; and the mis-match between domestic violence and the medical model. The conclusion indicates a need for collaboration based on effective links across the domestic violence community and the health policy community.

Keywords: Australia; Domestic violence; Policy; Women; Women's movement

Introduction

This article reports on the findings of the Australian component of an international study of health and domestic violence in five countries (Australia, Canada, Bangladesh, Thailand and Afghanistan). It explores possible explanations for the secondary role taken by health services in Western Australia. It adds to analyses of the health implications for women experiencing domestic violence (Campbell, 2002; Hegarty, Gunn, Chondros, & Small, 2004; Mouzos, 1999; Parker & Lee, 2002; Quinlivan & Evans, 2001; Resnick, Acierno, & Kilpatrick, 1997; Roberts, Lawrence, O'Toole, & Raphael, 1997; Roberts, Williams,

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Lawrence, & Raphael, 1998; Taft, 2002; WHO, 2002). Further, the study has implications for the organisation and cost of women's health care. For example, the annual cost to the Australian economy of domestic violence has been estimated to be in excess of AUD8 billion dollars (Access Economics, 2004) of which approximately AUD388 million is attributable to health costs. Despite this, the role of the health sector in the process of the prevention and care for victims of domestic violence has been secondary to that of the legal system in Australia.

Background and context

The legal/judicial system is the cornerstone of responses to domestic violence in many western countries. Australia is no exception. Criminal sanctions are widely recognised as having an important role in the process of prevention of domestic violence (see for example Busch & Robertson, 1994; Office of Women's Policy, 2002) because criminalisation has long been acknowledged in the literature, and in service provision, as performing a function that is highly symbolic in reinforcing legal and social norms (Holder, 2001). This being so, those committed to the prevention of 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 to women's intimate relationships. Use of criminal justice to address domestic violence sits nicely with political realities because governments can be 'seen to be doing something' about domestic violence.

International research has reinforced the centrality of the legal system in co-ordinated and integrated responses to domestic violence (see for example Domestic Violence Prevention Unit, 2000; Edleson, 1991; Edleson & Tolman, 1992; Minnesota Center Against Violence and Abuse, 2001; Pence & Paymar, 1993; Syers & Edleson, 1992). As a consequence, attention has focused on the need for a cultural change in police departments to facilitate appropriate responses to domestic violence incidents. Initiatives have included mandatory arrest (Williams & Hawkins, 1992) and, in the civil jurisdiction, the use of violence restraining orders (Family and Domestic Violence Taskforce, 1996; Graycar & Morgan, 1990). In contrast, the role of the health sector remains underdeveloped and its importance only recently highlighted (Clark, Burt, Schulte, & Maguire, 1996). This is despite WHO (2002, p. 101) suggesting that women who experience violence, whether it be in childhood or as an adult,

> experience ill-health more frequently, than other women—with regard to physical functioning, psychological wellbeing, and the adoption of further risk behaviours. A history of being the target (sic) of violence puts women at increased risk of depression, suicide attempts, chronic pain syndromes, psychosomatic disorders, physical injury, gastrointestinal disorders, irritable bowel syndrome and a variety of reproductive health consequences.

This scenario applies to Australian women. For example, between 1989 and 1998 in Australia, 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 (Mouzos, 1999). Additionally, women reporting domestic violence are 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). They are more likely to use medication for depression and anxiety (Resnick et al., 1997), tranquillisers and sleeping pills (Campbell, 2002), and they are more likely to have psychiatric disorders (Roberts et al., 1998) and drug and alcohol problems (Quinlivan & Evans, 2001; Roberts, et al., 1997, 1998). Injuries to their eyes, ears, head and neck as well as the breast and abdomen, especially during pregnancy, are common in women attending Australian hospitals for treatment (Campbell, 2002). These health implications of domestic violence occur across the lifespan and persist for many years (Hegarty et al., 2004; Parker & Lee, 2002; Quinlivan & Evans, 2001; Taft, 2002). Clearly, the active engagement of health departments in government policy and responses to domestic violence is vital.

Across-government responses and domestic violence

The domestic violence literature highlights the importance of responding to victims through the provision of co-ordinated services within 'across-government' frameworks that provide a holistic response to the complex issue of domestic violence (Balzer, 1999; Hague, 1998; Hill, 2002; Holder, 2001; Humphreys & Holder, 2002; Syers & Edleson, 1992). Such a framework can, potentially, deliver a seamless support services to women thereby