NSW Health Policy and Family Violence

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Introduction
This paper challenges the conception of domestic violence that is fore-grounded in NSW Health policies about domestic violence. The broad aim of the paper is to advocate for a reconstitution of the issue ‘domestic/ partner/ family violence’ in NSW Health policy. The problem representation of family violence advocated for in this paper recognises the multiple systems of oppression operating in the NSW context, systems that implicate both men and women. In particular, this paper argues for the issue economic disadvantage - and forms of marginalisation directly associated with this – to be recognised as a risk factor for both doing and being victimised by family violence in government policy. Greater visibility of this issue not only in Health policy but also across government could enable interventions that are more respectful of the dilemmas experienced by humans in our efforts to live in relationship with others.

In writing this paper I join with a number of others who in recent years have named the limitations of legal and second wave feminist constructions in preventing interpersonal violence, notably Razack (1998 & 2002), Turpin & Kurtz (1999), Watson (2001) and Joyner (2000). I join particularly with those writers / reports, including McKendy (1997), Hood (1998) and the World Report on Violence & Health (2002), that have advocated for class inequality and poverty to be recognised as prominent risk factors for violence in the home.

I assume that there are a number of ways we can conceptualise, or know about, the issue of partner violence. However, the story told in NSW Health policies addressing this form of interpersonal violence that I critique here is a particular one, and has been a fairly consistent one since the arrival of the issue in Health’s agenda, informed by

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1 Second wave feminist construction fore-grounded gender inequality as the cause of domestic violence and paid minimal attention to the oppressive systems of class and race in informing this issue.
certain knowledge claims. This story has materialised both in procedural documents and NSW Health workers practices.

**The NSW Health Story of Domestic Violence**

In NSW Health’s story about domestic violence women are the victims and men are the perpetrators. The NSW Health 2003 Domestic Violence Policy states that the terms ‘women’ and ‘victim’ are used interchangeably throughout the document (p.69) because domestic violence is (exclusively it would seem) a gendered phenomenon. In the NSW Health story women considered most vulnerable to domestic violence include pregnant women –any pregnant woman -, young women and women who have disabilities. With regard to men, who are construed only as potential perpetrators of violence in the story, no indication is given that one male is more likely than another male to use violence toward his partner. Other major knowledge claims that a health worker would derive about domestic violence from a reading of the policy story include:

- Interpersonal violence can be separated from the other parts that make up people’s lives. Hence, it is possible for health workers to intervene in the other parts (drug use, depression) while steering clear of a patient’s use of violence.
- Working with perpetrators / men who use violence requires the involvement of the legal system and a level of specialisation outside the reach of Health workers.
- Domestic violence is the sole responsibility of the perpetrator (a stated policy principle, *NSW Health 2003 Domestic Violence Policy*, p. 5).
- Perpetrators of domestic violence (men) hold all the power and use sophisticated scheming in the abuse of their partner.

**My Agenda**

For a number of years I have been interested in how workers in the domestic and sexual violence fields are allowed to know about interpersonal violence. I have

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2 I do not aim here to provide a comprehensive description of how this story became the dominant Health discourse about domestic violence but consider the story is the result of co-opting second wave feminist claims with legal discourse. See Lake (1999) for a detailed historical account and Ferraro (1996) and Evans (2002) for other accounts.

3 The exception to this in the policy is indigenous perpetrators of violence where the advocated response is whole of indigenous community.
undertaken documentary and field research to help me understand what discourses inform the surveillance practices that occur in these fields. I am not new to the controversy evoked when knowledge claims about interpersonal violence are questioned. In the midst of the tangle that is ‘knowledge’ about interpersonal violence I ask myself the following:

Who gains and loses most when we construe women as being non-violent or somehow not responsible for violent behaviour?
Who gains and loses most when we peddle the line that violence occurs ‘across all socio-economic groups’ without acknowledging the higher rates of violence among groups experiencing poverty?
Can we be clear about where the responsibility for violence lies?
What kinds of violence is our government trying to prevent? What kinds of violence is NSW Health trying to prevent?
Is this the violence that people suffer from most in their everyday lives?

Huge questions that are not answered here but are entwined with the observations fore-grounded in this paper.

Health workers perceptions of the issue interpersonal violence: A Study
As part of my role as a Health Improvement Consultant, and in anticipation of the new NSW Health 2003 Domestic Violence policy release, in 2002 I invited a number of staff from my Area Health Service (AHS) to participate in focus groups, to gauge how effective staff consider interventions with patients living with family violence. The study involved conducting seven focus groups in six departments with a total of 38 participants. The semi-structured interviews were recorded via audiotape or handwritten notes and the data analysed thematically. Departments included in the study were Drug & Alcohol Services, Mental Health Services, Emergency, Community Health, the Antenatal Service and Delivery Suite.
The aspect of the findings that I use for the purposes of this paper is that data that assisted me in understanding what health workers include as examples of family violence. Strategically, ‘family violence’ was not operationalised for participants in
the focus groups; it was deemed we could learn what workers considered ‘family violence’ was from the stories they told and examples provided.

I canvass here a selection of the stories told by workers to indicate the tapestry of examples of ‘family violence’ provided. It will be evident that many of the stories told interrupted what McKendy (1997) has coined the ‘universal risk theory’ of male to female violence. This theory promotes the belief that all women are (equally) at risk of violence because they are women. In contrast, examples given by many workers expressed the intersections between partner violence, mental health issues, chaotic and unpredictable lifestyles, child neglect, drug use and poverty.

On the following page in parenthesis I include the department where the example was given, a detail that has value but should not be assumed to be an exhaustive descriptor of how all staff in departments conceptualise the issue. One sound reason for naming the department where the example was given include assisting you to understand how the client group of that department may have impacted the constructions of family violence discussed, for example, Antenatal and Delivery Suite staff see female clients exclusively.

Please remember this is not an exercise in stigmatisation, it is a representation of how participating health staff view the issue family violence as informed by their work.

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4 A potential limitation of not defining the term was that workers may have chosen not to tell some stories due to lack of clarity about what appropriate examples of family violence are.

5 An example of this belief in NSW Health literature can be found in current What to do if you have been sexually assaulted pamphlets where it is stated that there is nothing about an individual women that makes her more or less at risk of experiencing sexual assault.

6 Developing theory that avoids stigmatisation of groups has been a conscious strategy of many feminist advocates who are concerned that stigma will complicate efforts to mobilise against domestic violence (Crenshaw 1997: 185).
Some comments made by focus group participants

“The women in domestic violence situations are the ones who don’t keep appointments, don’t have much money, are single parents or attend the clinics for high-risk groups (eg. Drug Use in Pregnancy Clinic)” (Antenatal Clinic).

“(I) have a female client who throws knives at her partner during arguments, uses the frypan over her partner’s head” (Community Health).

“Often these women have had multiple partners parenting their children and have used drugs. Their stories are often inconsistent and they arrive in established labour” (Delivery Suite).

“There are blurred lines between victim and perpetrator in the housing estates where we are working…women who are both perpetrating and are victims of violence” (Community Health).

“Many clients have the mix of illegal drug misuse, alcohol misuse and violence toward their partner…can be escalating violence when they are de-toxing” (Drug & Alcohol Service).

“Many of them have a history of sexual abuse or were abused as kids” (Drug & Alcohol Service, Mental Health Service).

“Clients with not much education… poor, drug use, domestic violence…” (Drug & Alcohol Service).

“She is being hit by her partner and the children are being neglected” (Community Health).

“She had just given birth and her mother (many people were living in the household) was being really abusive” (Community Health).

“Connections between the mental health issue, poor living conditions and the violence, showing the huge impact mental illness has on the kids” (Mental Health Service).

“Domestic violence may not be the most important issue you need to deal with… domestic violence can be an effect of the mental illness as well as a cause” (Mental Health Service).

Another study, so what? Methodology and domestic violence
Having read reams of debate on what studies of partner violence can or cannot tell us\(^7\), I agree with others (O’Leary & Murphy 1994, Straus 1993) that the issue of methodology only partially explains how we arrive at different conclusions about the nature of family violence. Questions of politics and values in research cannot be reduced to questions of methodology and the political struggles in the family violence field will not be resolved this way. Key to resolution is sharing a belief about what the phenomena referred to here as ‘family violence’ can include.

The participant comments I have selected for this paper are a biased selection but should not be dismissed for that reason: my intention here is to highlight that workers in this study recognised there is an interplay between violence in the home and poverty or issues that conspire to create poverty (drug misuse, family disruption, low education levels, mental illness). While further research is needed to understand the relationship between poverty, related social inequity and family violence, this study compliments the findings of some survey and census based studies that have found people from low socio-economic groups are over-represented in populations that use or experience violence at home. For example, looking at a sample of 500 referrals to the Child Protection Service at Adelaide Women’s and Children’s Hospital, Hood (1998) found that the bulk of the children came from poorer families and lived in moor poorly resourced suburbs. Through examining data collected from 59,000 households in the US National Crime Survey, Schwartz (1998) found a highly significant relationship between income level and spouse assault. Like Straus (1991) has argued, this US study also found that greater severity of violence inversely correlates with class level. From reviewing research and my own experience in the field, I would argue that we cannot afford to exclude the issue of poverty in NSW Health policies about violence in the home.

There is greater reference in the recent NSW Health policy to the importance of ‘primary prevention\(^8\), which via AHS discretion could involve developing programs targeting a wider range of social inequalities including economic. However, below I suggest that the promise of AHS encompassing a broader perspective about family

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\(^7\) A good example of this kind of debate is the mass production of comment arising out of the US Family Violence Surveys employing the Conflict Tactics Scale, used by Straus & Gelles: 1975 & 1985

\(^8\) AHS are instructed to devote time to preventative programs in schools and provide parenting support programs. Also, AHS are instructed to ensure that intake procedures include the prioritisation of the most vulnerable as a means of prevention and recognise cultural diversity in the planning of intervention strategies.
violence in their work may be thwarted by a directive that reproduces the same old story and narrow beliefs: routine screening for domestic violence.

The Routine Screening Initiative: Same Old Story
Several commentators, including voices here at the conference, alert us to how in developing policy selected propositions about the social world are deployed to produce specific problem representations. As I have suggested above, the problem representation of domestic violence in NSW Health (and most other NSW Government Departmental policies) is that in the home men as a group direct violence toward women as a group; and this occurs in a system that supports gender inequality. Given this problem representation, it is consistent to assert (as Health policy does) that women and children only are worthy of intervention; men from any socio-demographic group cannot be real ‘victims’ in a patriarchal social system.

Foregrounding of gender inequality as being the reason for violence in the home occurs repeatedly in the former and current NSW Health Domestic Violence policy and procedures via statistics cited and the research papers referenced. Another story reproduction tool is the directive that AHS implement routine screening for domestic violence for all women over the age of 16 attending key hospital departments. AHS are directed only to include women in the screening and the point has been strongly made in Departmental meetings I have attended that men are not to be screened for domestic violence. The policy makers have a story about the problem and they are sticking to it.

Implementing an initiative such as routine screening is time and labour intensive; the practical issues of organising and recruiting staff for training, inserting the screening questions in existing assessment tools and developing data catchment systems is extremely if not all-consuming for those with responsibility in implementation. My concern is that in our consumption we will stop asking questions like ‘how will screening for domestic violence realistically reduce levels of interpersonal violence’ or consider thoroughly any damaging unintended consequences this practice will

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9 The four routine screening questions are: 1. “Within the past year have you been hit, slapped or hurt in other ways by your partner/ ex-partner?” 2. “Are you frightened of your partner/ ex-partner?” 3. “Are you safe to go home when you leave here?” 4. “Would you like some assistance with this?”

10 It is mandatory for AHS to implement domestic violence screening for women in Drug & Alcohol, Mental Health, Antenatal and Early Childhood Services.

11 A possible consequence that would be harmful is Health workers failing to consider safety issues for men who are in abusive heterosexual or homosexual relationships.
have. My concern is that the routine screening initiative – by virtue of both being inclusive only of violence toward women, and consuming of AHS limited capacity to develop services - will get in the way for some of promoting richer understandings and practices in the area of interpersonal violence.

**Inclusive Understandings: WAHS’ Interpersonal Violence Strategy**

The NSW Health story of ‘domestic violence’ does not acknowledge the rich body of knowledge that has been developed about the complexity of interpersonal violence. For example, it can be known that partner violence is not a unitary concept but materialises as differently as there are number of couples. Also, violence in relationships does not necessarily occur linearly (one member having ‘power over’ the other) but can be a dynamic of behaviours (Johnson & Ferraro 2000). It can be known that the co-existence of, and overlap between, domestic violence and other forms of violence in the home & community is great (Tomison 2000, Slep & O’Leary 2001, World Report on Violence & Health 2002). It can be known that violence toward one’s partner does not necessarily occur in a systematic way but can occur in response to discrete, stressful events (Gilgun 2001, James et al. 2002). It can be known that members of a couple will often perceive their spouse is to blame for causing the violence, not themselves (Cantos et al. 1993). It can be known that women and men both use violence with the important common denominator that perpetrators and victims of family violence frequently have histories of childhood violence, and frequently have experienced layers of social disadvantage including poverty (World Report on Violence & Health, 2002)\(^{12}\).

The service where I am employed is currently embarking on a brave venture that accommodates more inclusive ways of understanding domestic/ partner/ family violence. Our service is in the latter stages of writing, and earlier stages of implementing what we are calling the Interpersonal Violence Prevention Strategy. The Strategy has been informed by an extensive literature search on the issue partner abuse, covering a range of discursive constructions of the issue. The Strategy reflects the principles that have been reflected in a number of recent Public Health documents, including ‘*Healthy People 2005*’ (NSW Health), which states that greater emphasis on

\(^{12}\) All of these knowledges are, of course, politically charged.
addressing specific determinants of health among people with higher levels of
disadvantage must be a priority area for AHS. This Strategy reflects also the still in
draft Health & Equity Statement\textsuperscript{13} which is concerned with combating differences in
health associated with the social and economic environments in which people live.
WAHS’ Interpersonal Violence Prevention Strategy will encompass the requirements
of NSW Health Domestic Violence policy, however, simultaneously aims to subvert
the story. Our agenda is to challenge - and eventually change in practice – the use of
an exclusive gender inequality lens to make sense of family violence. We aim for
workers in the area to have an understanding of violence that is rich in appreciating
the multiplicity of social inequalities that inform the doing of violence – including
class disparity - as a means of engaging in the prevention of violence more
adequately.

\textbf{Conclusion}

This paper has argued that the construction of ‘domestic violence’ in NSW Health
policy is too narrowly conceived. It has been posed that the problem of family/
interpersonal violence occurs in an environment that supports multiple systems of
oppression, including economic related oppression, implicating both women and men.
Recognition multiple systems of inequity (rather than gender inequity exclusively)
will disturb the NSW Health story of domestic violence but, it has been argued, would
enable prevention efforts that accommodate the complexity of why violence occurs.

\textbf{References}

\textsuperscript{13} The Centre for Health Equity Training Research Evaluation (CHETRE) together with the University
of Western Sydney were contracted by NSW Health to develop this Statement.


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