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- applying research evidence to health issues thus translating research into better health practice and outcomes; and
- promoting informed debate on health and medical research, health ethics and related issues.

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It is planned to review this manual in 2007. For further information regarding the status of this document, please refer to the NHMRC web address: www.nhmrc.gov.au

When it's right in front of you

Assisting health care workers to manage the effects of violence in rural and remote Australia

Endorsed 30 August 2002

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Introduction

The impact of violence on the physical and mental health of individuals, families and communities can be severe and far-reaching. There are many different kinds of violence. It may be from person to person or self-inflicted. It may be physical, sexual or verbal abuse, harassment, bullying or discrimination. Violence does not 'belong' to any one community, culture or group of people in Australia. It affects people of all ages and all backgrounds.

Resources for coping with the effects of violence are limited, particularly in rural and remote Australia. As well, health care workers in rural and remote areas face unique challenges (such as isolation and limited support) which can make managing episodes of violence even more difficult (CRANA 1999a). It is also increasingly likely that workers within the health industry will be targets of physical or verbal abuse (Perrone 1999).

The National Health and Medical Research Council (NHMRC) has developed this manual for health care workers, managers and employer organisations in rural and remote Australia, to help them prepare for and respond to violence in ways that will minimise its impact.

There is a range of reasons to address violence in rural and remote Australia, including:

- evidence that violence is more common in remote areas than in urban areas (Moller 1994; AIHW 1998)
- reports of burn out, injury and harm to rural and remote health care workers (CRANA 1999a)
- legal implications that all health care workers need to be aware of, especially when the law changes
- reporting requirements which vary across Australia
- differing infrastructure and resources across rural and remote Australia to manage violence and its outcomes
- limitations imposed by distance and isolation
- the need to bring national attention to this difficult subject.

The NHMRC is committed to working with others. This manual was developed by an Expert Working Party, many of whose members volunteered for the task after a workshop at the 6th National Rural Health Conference in March 2001. Several members are from rural and remote health care organisations. A list of Working Party members, together with the terms of reference, is given on page 77.

The development of the manual has been informed by widespread consultation with stakeholders and further refined by a workshop of professionals in the field. As well, the NHMRC commissioned a review of literature and resources related to violence in rural and remote Australia.¹ The literature review identified a clear need for quantitative research into the extent of violence in rural and remote Australia.

Currently, there is no nationally recognised resource that discusses evidence on the extent of the problem or provides tools to assist health workers in managing episodes of violence. This manual should be seen as a first step towards such a resource. While the quality and extent of the literature is not sufficient to use as the basis for recommendations, the manual combines experience, consensus and available evidence to make suggestions about options for action and to highlight gaps in knowledge.

1. The report of the review is available from the NHMRC

AIM AND SCOPE OF THE MANUAL

This manual aims to assist you, as a health care worker or manager in rural or remote Australia, in responding to incidents as they occur and minimising the impact of episodes of violence. It provides practical guidance and identifies useful websites and references which provide more specific information. The manual should not be used as a source of legal advice. If you are uncertain about legal obligations you should contact a lawyer for assistance (see *Further resources* in Chapter 5).

The manual aims to encourage partnerships and capacity building at local level, recognising the variety of employers, settings and circumstances in different rural and remote areas. Because of this diversity, the manual cannot tell you exactly how to manage each episode of violence. You will need to assess the situation and your responses will be influenced by a range of factors including:

- your profession
- the type of community you work in
- the degree of isolation of the community
- access to emergency services (such as the police), referral and other agencies
- your employment arrangements
- organisational policies already in place.

Being prepared can make dealing with episodes of violence less difficult. This involves gathering information that is relevant to your local service and region, developing policies and procedures that will work in a particular situation, and setting up support systems to assist the recovery of victims of violence, the health service and the community.

The Working Party recognises that the causes of violence are highly complex and diverse. While the epidemiology of violence in rural and remote areas is described in Chapter 1, this manual does not attempt to explain, address or solve issues in society that result in violence. However, it is hoped that NHMRC recognition of violence as a major public health problem will be a useful step in bringing those issues into national focus.

STRUCTURE OF THE MANUAL

The manual addresses the two main categories of violence that health care workers and managers may encounter:

- violence suffered by clients – including physical assault, self-harm and suicide, family and domestic violence, child abuse, sexual abuse, harassment and bullying, and violence due to homophobia or racism (descriptions are given in Tool 1)
- occupational violence – including violence or threats from clients, conflicts between workers or between managers/employers and workers, and random acts of violence that have an impact on the health service (see Section 4.1 and Tool 1).

The manual is in three parts. Part A comprises a series of chapters which discuss theory and evidence drawn from the literature review and other relevant sources. These include discussion of:

- rural and remote practice, barriers to preventing and managing episodes of violence in these settings and ways of being prepared to meet the challenges (Chapter 1)
- ways of dealing with the complexity of violence in rural and remote settings so that you are better able to meet the health needs of people affected by violence (Chapter 2)

- ways to avoid burn out and cope with traumatic stress, and sources of support (Chapter 3)
- how managers/employers can develop a safety net to protect workers from violent episodes and their aftermath (Chapter 4)
- legal responsibilities of health care workers and managers when dealing with violence (Chapter 5)
- ways to work with other organisations and your community to improve local outcomes (Chapter 6).

Each chapter in Part A has a checklist for action to help you be aware of your rights and responsibilities and feel able to identify situations of risk and develop strategies to manage them (a risk management approach). The final section of each chapter lists resources and references that can be consulted if further information or support is required. Chapters 2, 3 and 4 also have summary tables that give different sample scenarios and list issues to consider and some options for action for each scenario.

Part B contains practical tools to assist health care workers and managers/employers in deciding how to prepare for and manage episodes of violence, based on the information in Part A. It includes tools to assist you in managing violence in your setting, including sample case notes and incident reports, an occupational violence policy, forms for documenting risk management and case studies to show how the information contained in the tools can be put into practice.

Part C aims to help you decide where to begin in minimising the impact of violence in your community. It includes a variety of approaches to using the manual and developing a program for managing episodes of violence. You can choose one or more of these approaches, alone or as part of overall training and evaluation in your organisation.

1 Rural and remote health practice – an overview

Before looking at specific ways to manage episodes of violence, it's important to take a look at the bigger picture including:

- what it's like being a health care worker in rural and remote Australia
- why violence is a problem in these areas
- barriers to dealing with violence
- suggested options for action (these are described in greater detail in later chapters).

1.1 THE CHALLENGES OF RURAL AND REMOTE HEALTH PRACTICE

Definitions of 'rural and remote' differ according to whether they are based on population or on degree of geographic isolation. According to the Rural, Remote and Metropolitan Areas classification,² which is based on population numbers and an index of remoteness, about 29 per cent of the Australian population (including 64 per cent of the Indigenous population) live in rural and remote areas (AIHW 2000).

Rural and remote health practice is characterised by diversity – of roles, employers, settings and the types of communities in which health care workers are employed. However, there are common challenges that differentiate rural and remote health practice from urban practice. For example, professional and social isolation has been identified as a major issue affecting health workers in rural and remote areas (White & Fergusson 2001).

Remote communities³

Remote communities are usually small, with populations of less than 5,000. They can be Aboriginal or Torres Strait Islander, mining, tourism, offshore island, railway, or pastoral communities.

Remote health care workers may be employed by state/territory governments, mining companies, independent Aboriginal community-controlled organisations, the Royal Flying Doctor Service, local community boards or councils, religious affiliated organisations, or bush nursing associations. Some medical practitioners may be wholly or partly self-employed. Remote employers tend to be located in the nearest regional centre, which may be hundreds of kilometres away from the community itself.

The professional role of remote health care workers will depend on the type of community they serve, for example those working for mining companies, tourist islands or oil rigs tend to focus on providing accident and emergency responses. Probably the most common form of health service delivery in remote areas is a community clinic staffed by a small multidisciplinary team of generalist health care workers. The team is usually made up of Aboriginal or Torres Strait Islander health workers (if an Indigenous community) and remote area nurses. Sometimes a doctor is part of the on-site team, but most often doctors live in a regional centre and provide visiting services and emergency support by telephone. This may be done in conjunction with the Royal Flying Doctor Service. In some remote areas, availability of supporting health services may be limited to fortnightly visits, and assistance from other services (eg police and emergency services) may take even longer.

2. The classification was developed by the Commonwealth Departments of Primary Industries and Energy and Human Services and Health, based primarily on population numbers and an index of remoteness.

3. This section is largely based on information from CRANA (1999a) and Kelly (2000)

Between them, the small on-site team provide a 24-hour emergency service, as well as the full range of health care services for the community – acute and chronic care, referral, follow-up and rehabilitation, health promotion and illness prevention, and population and public health programs. If a community member needs hospitalisation they usually need to go to the hospital in the nearest town.

Services like on-site doctors, pharmacy, x-ray, pathology, ambulance, dentists, mental health practitioners and other specialist services are usually not available on-site in remote communities. They are commonly provided by visiting health care workers based in the nearest regional centre. The lack of referral points leads members of on-site teams to extend their professional role to provide basic elements of the range of ‘missing’ services. This is called adopting an ‘extended generalist role’.

Remote health care workers are expected to be ‘jack of all health trades’ and to manage a wide range of health and social issues at an individual, family and community level. While this can be exhausting and overwhelming at times, it can also be very rewarding when things go well.

Staff turnover of health care workers is often high in remote communities (Kelly 1999a). This may be partly due to the nature of the job and its demands in comparison with urban practice. When staff turnover is high, it can be difficult to provide effective health care as workers are often at the beginning of their learning curve. A range of strategies has been used to attract health care workers to rural and remote areas, but there is no evidence as to their success so far.

Rural communities

Issues in rural health tend to be similar to those in remote areas but are likely to be less extreme, as other health services, practitioners and regional hospitals are usually closer or easier to access. However, access to specialist services and advice is often limited, and health care workers in rural areas also need to possess a broad range of ‘specialist generalist’ skills to meet the wide variety of client needs.

An additional challenge in rural areas is providing 24-hour a day care and protection in an inpatient setting. Staff may be expected to regularly travel long distances to provide health care services to outlying areas in the region. As well, providing adequate aged care services is a growing issue in rural areas with ageing populations.

Recruiting and retaining adequately prepared health care workers to rural areas continues to be a problem.

Facing the challenges

Each rural and remote community is unique. Part of the challenge for rural and remote health care workers is to gain an understanding of how that particular community ‘works’ socially, culturally and politically in order to become effective in their practice. This means that they must build relationships based on trust with individuals, families and the community. This can take time.

The lack of anonymity in small communities can lead to a job becoming 24 hours a day, seven days a week, whether the health care worker chooses this or not, and whether their employer supports and insures them to do this or not. Being expected to provide consultations in the local store is a good example of this. It can be difficult to refuse requests and still maintain credibility and social relationships within the community.

Isolation and lack of support can be a big challenge. Low staff numbers mean that there may only be one or two staff members on shift, especially after hours, and assistance from police and other emergency services may not be readily available.

Providing everyday care can be demanding enough. Emergency situations such as break-in attempts during the night, treating those affected by alcohol or drug use, safely managing psychiatric emergencies, or managing a tragedy such as an unexpected death, can place great stress on health care workers. Everybody knowing everybody else can complicate and intensify the impact of these types of events on all involved.

Another challenge for rural and remote health care workers is juggling the wide range of roles they undertake – these may include employer organisation representative, manager, service deliverer and community member. Balancing all these roles is part of everyday life, but can cause tension when something goes wrong.

Ways in which health care workers can avoid burn out, cope with traumatic stress and get support are discussed in Chapter 3.

1.2 IS VIOLENCE A BIGGER PROBLEM IN RURAL AND REMOTE AUSTRALIA?

The literature review conducted for the manual found that the extent of violence in Australia in general and in rural and remote areas in particular has yet to be fully documented. There is an absence of robust measurement of the incidence and prevalence of violence in rural and remote Australia. While there are regional statistics available, their results cannot be generalised more widely because of the diversity of rural and remote settings and likely bias due to under-reporting.

Major gaps in the literature documented in the literature review include the following:

- there is limited information on the prevalence of or trends in different forms of domestic and family violence in rural and remote Australia
- currently available data on violence towards the aged or suicide among the elderly population in rural areas are limited and patchy
- there has been little research on the relationship between being a victim of interpersonal violence and self harm or suicide
- there is a lack of substantial evidence on violence towards health care workers.

The literature review found the following evidence:

- interpersonal violence was among the most common new health conditions across Australia in 1996, with around three people per 1,000 population requiring hospitalisation or attending a hospital emergency department (AIHW 2000)⁴
- death rates from interpersonal violence are fairly constant across rural and urban areas (James & Carcach 1997; Mouzos 2001a), but rise sharply in remote areas to rates three and a half to five times as high as other areas (Moller 1994)
- from 1986 to 1995, firearms-related death rates from all causes were highest for rural areas and lowest for capital cities (ABS 1997a)

4. Although death registrations and hospital statistics give some indication of levels of intentional injury, they do not tell the whole story. Not all victims of violence are admitted to hospital or killed, and not all results of violence are physical. Under-reporting of violence is a major issue.

- death rates and hospital admissions due to injury are moderately higher in rural areas, but two to three times higher in remote areas compared with capital cities. In remote areas, approximately 20 per cent of these extra deaths are attributable to suicide and 10 per cent to interpersonal violence (AIHW 1998)
- suicide rates among males are almost 50 per cent higher in 'other remote areas' than in the rest of the country (Moller 1994)
- a greater proportion of Indigenous homicides (46 per cent) occur in rural and remote locations compared with non-Indigenous homicides (16 per cent), although this is not unexpected given that Indigenous people are more likely than non-Indigenous people to live in rural and remote areas (Mouzos 2001b)
- while rates of sexual assault vary little between metropolitan and non-metropolitan areas (ABS 1997b), the overall rate makes it an important issue, with around one third of Australian women and about 8 per cent of men likely to experience sexual violence during their lifetime (AHMAC & RANZCOG, in press).

Domestic and family violence

The literature on types and severity of violence in rural and remote Australia suggests that:

- domestic and family violence accounts for by far the greatest proportion of violence (ABS 1997b; Hogg & Carrington 1996; Aboriginal and Torres Strait Islander Women's Task Force on Domestic Violence 1999)
- there is a higher incidence of domestic and family violence in rural and remote communities, with Indigenous women more likely to be victims of such violence and likely to sustain more serious injuries (WESNET 2000)
- women experience domestic and family violence at greater rates than men (Cook & Griffiths 1994; Queensland Health 1999; WESNET 2000).

Suicide and self-harm

In relation to suicide and self-harm in rural areas, the main findings from the literature are that:

- there has been a marked increase in suicide among young males in rural areas across Australia over the last two decades (Dudley et al 1998)
- rates of suicide among young males in rural areas are higher than those in urban areas (NSW Legislative Council 1994; De Vaux 1996; Reynolds & Conroy 1999)
- the availability of firearms in rural areas contributes to a high rate of firearms suicide in these areas (De Vaux 1996; Baume & Clinton 1997; Officer et al 1999)
- there is evidence of increasing rates of suicide in traditionally oriented Indigenous communities (Hunter et al 1999).

Violence against health care workers

Violence in the Australian health care sector is generally poorly recognised and little literature on violence directed against health care workers in Australia is available (Mayhew & Chappell 2001a). However, there are indications that:

- the majority of health care workers in rural and remote Australia can expect to experience some kind of violence (Perrone 1999; Tolhurst et al 1999)
- remote area nurses in smaller communities, on call and with limited availability of support and backup, may experience more violence than their urban counterparts (Fisher et al 1996).

Vulnerable groups

There is evidence that in Australia as a whole, certain population groups are particularly vulnerable to violence, because of gender, race or sexuality, or because they lack power in relationships. While there is no information about the prevalence of this type of violence in rural and remote areas specifically, the high prevalence overall makes it an important issue in all areas. For example, there is evidence that in one quarter of all 'stranger murders' in NSW in the 10 years to 1996, the victim's sexuality formed the basis for a fatal attack (Tomsen 1997).

1.3 BARRIERS TO MANAGING EPISODES OF VIOLENCE IN RURAL AND REMOTE SETTINGS

Few rural and remote health care workers have been trained to deal with violence. Yet if police are not available to provide emergency support, or if that support is some time away, there may be few resources to call on for help, advice or an immediate response. This can leave rural and remote health care workers very vulnerable to the impact of violent episodes, particularly if no local response plan has been prepared.

There can be practical problems with meeting legal requirements such as mandatory reporting in rural and remote areas. Because of the small populations of many rural and remote communities, a health care worker may feel under pressure not to report an episode of violence even when this is legally required of them. The action may need to be taken against a relative, friend, acquaintance, fellow worker or employee. Lack of anonymity of all involved can make situations that are already difficult seem more intense and harder to deal with. However, mandatory reporting is a legal requirement and the health care worker has no choice in the matter.

Because everyone knows everyone else in small communities, the health care worker may be able to clearly see the potential impact and aftermath of the reporting. In some cases, their action can destabilise a whole community. On a personal level, taking action can result in the health care worker and their family being ostracised and made to feel that they have breached the community's trust. Conflict may also arise between the health care worker's personal ethics, the ethics of the community and the health care worker's professional code of practice.

Social and cultural influences in some rural and remote areas of Australia may seem to condone violence as an acceptable means to resolve conflicts or disputes. There may also be conflict between mandatory reporting and cultural sensitivity in some cases – for example, some communities may prefer that the community has an opportunity to manage or contain the situation first, while the law requires health care workers to report immediately.

Dealing with episodes of violence can be particularly challenging for many Aboriginal or Torres Strait Islander health workers, some of whom may be bound by kinship ties and responsibilities that can make it very difficult to choose, or perhaps not to choose, a particular course of action.

There is limited evidence relating to barriers to effective management of violence by health care workers. What there is suggests that appropriate multidisciplinary training is needed in relation to knowledge about violence, attitudes to victims of violence, communication skills and cultural sensitivity. The establishment of protocols and networks is also recommended, as is the maintenance of current information about services and legal issues (Dowd & Johnson 1995; Davies et al 1996; Bates & Brown 1998).

Maintaining insight

As well as difficulties in acting on episodes of violence, there are a number of challenges to maintaining the insight and clarity necessary for making the right decision:

- high levels of staff turnover in rural and remote areas mean that there is little continuity of knowledge or service
- health care workers may be tempted to take the law into their own hands if they feel community services are acting too slowly
- too much insight or knowledge about the community and its members can immobilise the health care worker
- without supervision or mentoring, the isolated health care worker can keep making the same mistakes with increasing levels of confidence, since they do not have colleagues to provide feedback or notice errors.

Finding different solutions

Different responses to violence are often needed in rural and remote settings when compared to urban environments where there are a range of resources available to provide support and back up. In fact, the lack of support resources may mean that urban responses to violence may be unsuitable or impossible to implement in rural and remote areas.

These differences include:

- the lack of police and emergency services on-site in many rural and remote communities – response times may range from 20 minutes to several hours or longer, by road or sometimes by air
- greater distances, which mean that response times of referral agencies can sometimes be measured in days or weeks rather than minutes
- the consequent need for health care workers to have special skills in de-escalating difficult situations before support/emergency services arrive
- the complications and time delays of organising transport of victims or perpetrators out of the community
- delays in apprehending violent offenders in rural and remote communities
- the lack of anonymity of all involved which may increase the risk to the victim
- geographic isolation making it difficult to enforce occupational health and safety legislation in providing a safe place to work

- the potential for difficulties in reporting violence occurring in the workplace
- the possibility of having to operate from insecure premises.

State and territory legislation will apply to rural and remote regions in the same way as it applies to urban regions. Even when finding different responses and solutions in rural and remote regions, you must work within the law.

1.4 BEING PREPARED

A health care worker's choice of action is guided by many considerations. These include legislative requirements at state and territory level, organisational requirements laid out in policies and procedures, professional requirements of their registering body, and the personal, ethical or moral requirements they have of themselves (based on their beliefs, ethics, time, place and community setting).

Having networks for support and mentoring

It is easy to feel alone when managing episodes of violence in small communities. Health care workers in rural and remote areas need to look after themselves so they do not become overwhelmed and burnt out by their work.

Adequate support from employers and from peer support networks is critical to help maintain personal and professional resilience and judgement. Psychological support can be useful in the aftermath of an episode of violence. The health care worker might wish to explore participating in a community-wide approach to violence management, such as an anti-violence/anti-alcohol initiative. Support mechanisms are outlined in Chapter 3.

Taking a risk-management approach

Violence is never going to be eliminated altogether. It is important to acknowledge this fact, and take an active role in risk management before the event. This means that health service providers assess the workplace and work activities for potential dangers before they arise (hazard identification), think about the likelihood of the risk occurring and the consequences if it did (risk assessment), decide on appropriate actions to reduce the risk of harm (risk control), undertake any other activities needed to reduce the risk of harm (risk control implementation) and provide for monitoring and review. This includes identifying barriers to managing the different types of violence that might be encountered, and also any social controls of violence in the community that could be used to overcome these barriers.

Risk management is discussed in detail in Section 4.3 and Tool 5.

Being informed

Health care workers need a clear understanding of the available options for action and knowledge of what is legally required in different situations.

While each chapter of this manual highlights the legal requirements and ethical considerations associated with various situations, Chapter 5 discusses these issues in more detail. It is important that organisations find out about the specific legislative requirements for mandatory reporting in their state or territory, so that all members know the types of violence that must be reported and that policy decisions can be made about other types of violence that may be reported. Websites with legal information are included in the resource section at the end of Chapter 5.

As well as mandatory reporting, health care workers need to be aware of their duty of care. This means doing everything reasonable to protect the health and ensure the safety of both clients and colleagues. Employers and managers also have legal obligations to ensure that the workplace is safe for all staff (see Chapter 4).

Setting up networks for referral

Many rural and remote health care workers do not have ready access to community services or even the police as points for referral during an episode of violence. Nonetheless, it is important that health care workers do not bear the brunt of violent episodes alone.

Wherever possible, health care workers need assistance from those who have been trained to deal with violence. The health service may choose to work in partnership with other community services and organisations, setting up networks to call on for referral and strategies to prevent or overcome problems with violence in the clinic and the community (discussed further in Chapter 6).

2 Caring for those affected by violence

For health care workers everywhere, caring for clients affected by violence can be a confronting and challenging part of the job. For health care workers in rural and remote areas, the challenge can be intense. You are likely to know both the victim and perpetrator. You are also likely to have to do much more for them than just treat the injury – for instance, counselling, finding safe places and managing the situation while waiting for backup from the police or community support service. This can involve making difficult decisions that may have an effect on the whole community.

This chapter aims to help you care for clients who are directly affected by violence by discussing:

- how to assess the situation and the risk of further problems
- the importance, in both medical and legal terms, of taking clear and accurate notes (see Tool 3)
- how to be prepared (eg having in place policies for managing incidents and referral networks).

The chapter also discusses your rights if you are the victim of violence.

2.1 ASSESSING AND DOCUMENTING THE SITUATION

Recognising signs and symptoms

Some episodes of violence are much more apparent than others. For example, injuries resulting from a fight at the pub may be fairly obvious. However, family and domestic violence can be hard to detect. Families may protect the perpetrator out of fear or loyalty. It can also be more difficult to recognise psychological and emotional abuse than the more obvious signs of physical abuse. Early identification of family and domestic violence is important because episodes may become more frequent and more damaging over time (Eastern Perth Public and Community Health Unit 2001).

Tool 1 describes some common forms of violence and lists common physical and psychological indicators of episodes of violence, and of homicidal or suicidal risk, which need to be acted on immediately.

Assessment and documentation

In cases where the cause of injury is acknowledged as an episode of violence, assessment is usually based on the injury and what to do about it (eg stitching up a laceration). Where there is a history of violence, or where the cause is not acknowledged as violence but you suspect that it is, assessment becomes more complicated. The following should usually be taken into account (Eastern Perth Public and Community Health Unit 2001):

- the client's past history of suspicious injury as well as their current injury
- whether there is a pattern of repeated use of emergency services
- whether the injury is consistent with the cause the client describes
- whether there was a delay between the time of injury and time of reporting (especially for children)
- whether the client seems evasive about the incident, or uneasy about going home.

Physical examination may include neurological assessment if there has been injuries to the head and X-rays may be required to assess old and new fractures. Photographs should be taken as soon as possible if there are physical injuries (with consent from the client; see Tool 3).

Psychosocial assessment should include assessment of the types of abuse, their frequency and severity, whether there has been the threat of weapons, whether there are children at risk and the strength of the client's support network.

Taking clear and accurate notes

In managing any episode of violence, it is important to keep accurate case notes. These are needed for your client's protection, for your protection, and for possible legal use in the future.

Clear and accurate case notes might include:

- relevant medical history obtained during the assessment
- demographic data such as gender and ethnicity
- the type of abuse and whether it is identified or suspected
- the injury suffered
- the cause of injury (if not disclosed, the suspected cause of the injury)
- the medical treatment needed, any other type of intervention provided and the referrals made
- whether a weapon was used to inflict the injury
- the relationship of the victim to the perpetrator
- the client's behaviour and the reactions of family members.

Use factual language and record the client's own words (or those of a support person) as well as your own assessment. Indicate if relevant photographic evidence was taken and whether body maps or schematic drawings were used (see Tool 4).

Details of police involvement should be documented if applicable.

Source: Adapted from Eastern Perth Public and Community Health Unit (2001).

Tool 3 provides additional material to support you in clearly documenting episodes of violence, including sample case notes, body maps and an incident report form.

2.2 PROVIDING A SUPPORTIVE ENVIRONMENT

Clients who have suffered a violent episode are likely to feel frightened and upset as well as hurt. They may appear agitated because they are 'pumped up' with adrenaline, or feel like expressing their anger about what has happened to them. However they react, clients are likely to recover faster if they feel they are in a supportive environment. Be aware that from the moment a client comes into contact with you, everything has the potential to affect their level of stress or distress. Issues that need to be thought through in a variety of settings include:

- the need for the service to be sensitive to the unique experiences of that person (eg language, gender issues, ways of communicating, privacy issues)
- the special needs of children in being listened to and protected.

In settings where there is only one health service, simultaneous presentation of victim and perpetrator can be a high-risk situation for both health care workers and clients. All due care should be taken to keep them apart, in different venues if possible.

If possible, interviews should be held in a private room, excluding anyone who might put pressure on the victim. Clients may prefer to be interviewed by staff of the same gender. They may also want to have a support person with them, and walk round the room rather than sit down.

Encouraging clients to talk about their experience of violence can give you vital information about their medical needs and safety risks. They may also find it therapeutic. At first, they may not want to talk – they may just want to cry. Being asked questions in a sensitive and non-judgemental way may help clients to express their feelings. It might also help if you can reassure clients that:

- they are not responsible for the perpetrator's actions
- there are immediate measures that can be taken for support and safety
- it is possible to talk through and seek solutions if violence is systematic and ongoing.

Tool 1 includes a list of questions you can use as a starting point. People react differently to stressful situations, and the timing and appropriateness of discussions about their experience of violence varies according to individual needs.

Dealing with different reactions

Sometimes clients may be angry about what has happened to them or about how their situation has been dealt with by the health service. If you react to the anger of others by attacking or withdrawing, you may make the conflict worse. If you choose to respond respectfully and calmly, you may be able to de-escalate the conflict and bring emotions to a level where the issues can be dealt with more constructively (Kelly 2000).

Sometimes anger arising from a client's past may be projected into the current situation. Such anger may be sudden and inexplicable. Developing an understanding of the political and historical environment of the health service and the community in which you work may help you to avoid such incidents and increase your safety and that of your clients (Kelly 2000).

Tool 2 suggests strategies to assist you in responding to anger of clients.

Going beyond the call of duty

Violence is not easy to deal with. When it is right in front of you, you know the people involved and there appears to be a long history of abuse, the situation may seem overwhelming and hopeless. But even when it seems the victim is caught in an endless cycle, you still have a responsibility to help victims of violence, in treating their injuries and helping them to avoid further harm, unless you are under immediate threat of harm yourself. Sometimes this can involve you well beyond the call of duty, particularly when other community support services and/or police have to be called in from elsewhere.

It helps if you are aware of your legal responsibilities, so that you know the types of violent incidents that you must report. Chapter 5 outlines some legal considerations.

2.3 REFERRAL AND SAFETY PLANNING

You need to know your limitations. Most health care workers have not been trained to deal with the causes or consequences of violence. However, at the very least, you will need to manage the situation until backup arrives (eg community support services, police). As part of this, it's important to look at the whole social context of the violence, and not consider the episode in isolation. Then you can identify all available resources and use the most relevant service depending on the situation (eg police or mental health services). It's also important to have referral networks in place so that you get the right help as quickly as possible and you don't feel that you have to manage alone.

In cases of family and domestic violence, the safety of victims or potential victims is paramount. While not all family and domestic violence is against women, the majority is and most services have been developed with this in mind. Options to help include:

- assisting victims to assess their own safety
- discussing their options for safe temporary accommodation if available (eg women's refuge, safe house network, family or friends, even overnight accommodation in the local hospital if that is available and acceptable)
- encouraging them to access specialist support services (eg women's health centre, social worker, counsellor, community nurse)
- informing them of their legal right to protection (eg obtaining a restraining order, laying assault charges) and referring them for legal advice about these and other legal options
- giving them safety advice if they are returning home (for people in an agitated state, written advice that they can refer to when calmer may be more practical)
- referring couples to specialised counselling services in the local area if available and appropriate.

If you feel that you or your client are at significant risk of violence and there are no resources for protection, your response and options will vary depending on the length of time until backup is likely to be available (eg minutes, hours or days). Factors to consider include:

- have the police been contacted for assistance and how long will it be before law enforcement arrives?
- who is at risk from the violence – clients or health care workers or both?
- is it possible and/or necessary to leave the setting/community?

If it's possible for the client or health care worker to leave the community and seek support elsewhere, then they should. If it's not possible, the client and any health care workers at risk should barricade themselves in a safe area until the risk subsides or help arrives.

2.4 WHAT IF YOU ARE THE VICTIM?

If you are the victim of violence, you are entitled to the same help as any of your clients in the same situation. If the violence is work-related, your employer has an obligation under occupational health and safety legislation to protect you from harm and to assist your recovery (see Chapter 4) and you have a right to make a workers' compensation claim for any physical or psychological harm that occurs in the course of your employment.

If the violence is not work-related, you have a right to be protected and cared for just like any other member of the community. Either way, you need to seek treatment and support and try to remove yourself from further harm. Your safety is paramount, and you have a right to feel secure at work and at home.

Reporting of violence, whether or not physical harm occurs, is a positive contribution to safety planning. Remember that violence also includes threatening behaviour, harassment, discrimination and verbal abuse. If you or a colleague has been threatened by a client or fellow worker, an incident report form should be completed even though you may be physically unharmed (see Tool 3). Your duty of care towards a client does not include submitting to violence (either from the client or someone accompanying them), and reporting the incident should not be seen as a betrayal of the client.

If you become aware that a fellow worker may be a victim of violence in the workplace you should notify your manager. Your organisation's policy on occupational violence should provide for debriefing and employer assistance (eg removal, counselling) (see Chapter 4 and Tool 4). You may be in a position to assist your colleague to access workplace supports which are in place. If their injuries are not work-related, you may choose to approach them as a peer and discuss with them their options for action.

2.5 WHAT ABOUT THE PERPETRATOR?

People who commit acts of violence are not necessarily 'bad'. In many cases, they are victims themselves – of abuse or neglect, or feelings of powerlessness. It is the violence that is unacceptable, not the people involved. But until perpetrators of violence accept responsibility for what they have done and take steps to prevent it happening again the cycle of violence cannot be broken. This is a difficult and complex issue for society and beyond the scope of this manual to address.

As a health care worker, if you become aware that a fellow worker may be a perpetrator of violence in the workplace you should notify your manager. Your organisation's policy on occupational violence should provide for appropriate treatment of the perpetrator (eg removal and counselling) within the framework of occupational, health and safety legislation, employment legislation and policies.

Chapter 6 outlines some ways that you, as a health care worker and community member, can work with others to increase community intolerance to violence, and to develop positive outcomes for both victims and perpetrators of violence. Tool 6 includes a range of suggestions for ways to work with the health service and the community to make your community safer.

2.6 CHECKLIST FOR ACTION

Have you?	Yes	No
Become aware of indicators of physical and psychological abuse? (See Tool 1)		
Identified individuals and families at risk from violence? (See Tool 1)		
Developed procedures for keeping accurate client records? (See Tool 3)		
Understood your legal responsibilities – when you have to report episodes of violence to the police or other community services? (See Chapter 5)		
Developed procedures for caring for abused or threatened clients, from reception, to interviewing, to referral? (See Tool 4)		
Considered the special needs of children in being listened to and protected?		
Identified a way to get threatened clients and/or health care workers out of the community to seek support elsewhere?		
Thought about cultural issues that may be important, such as relocation, discrimination, social isolation, going home after imprisonment, removal of children?		
Identified a safe area where threatened clients and/or health care workers can barricade themselves until the risk of violence subsides or help arrives?		
Asked victims for permission to disclose their information in order to progress that person's care options (making appointments etc)?		
Developed an agency referral list which includes contact names and phone numbers and is prominently displayed in your work area?		
Developed case management strategies with other agencies in the region?		
Completed an incident report form if you have been the victim of violence? (See Tool 3)		

SUMMARY TABLE

The following table sets out sample scenarios and some options for responding to violent episodes and overcoming barriers. You can use the table to help you think through what kind of responses might be appropriate in your community. These are just examples of the types of situations that may occur. You will need to assess your own situations and your responses will be influenced by local circumstances. A blank table is also provided. You may wish to make copies of the table and use them to record how you or your health service deals with incidents, so that you can refer back to them and gain an understanding of responses that have been effective in your community.

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
A young man is knifed by his older cousin (see sample case notes in Tool 3)	<ul style="list-style-type: none"> Is there a legal obligation to report act to the child protection authorities (given the age of the young man)? Should the matter be referred to the police? Possibility of repeat attack Safety of other family members Mental health issues Drugs/alcohol Cultural sensitivities 	<ul style="list-style-type: none"> Immediate medical attention Consider existing resources (eg people who can intervene) Make clear and accurate notes 	<ul style="list-style-type: none"> Family protection of perpetrator Community response to reporting 	<ul style="list-style-type: none"> Enlist community support (reporting is a continuation of the act rather than a separate event) Create a safety net through cooperation and coordination with other community organisations (mental health, police etc)

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>Population-based urine screening for STIs diagnoses three young people from the same family (aged 11–14) as positive for gonorrhoea</p>	<ul style="list-style-type: none"> • Is there a legal obligation to report to child protection authorities or state health department? • Should the matter be referred to the police? • Family situation • Interviews with children (with interviewer of same sex) 	<ul style="list-style-type: none"> • Consider who to report this to so that the family is properly informed • Community-police liaison • Refer to child protection agency (in community or external) 	<ul style="list-style-type: none"> • Family protection of perpetrator • Community response to reporting 	<ul style="list-style-type: none"> • Removal of perpetrator • Counselling for family and children • Normalising community life
<p>On a hot day there is a call to a house where children are found neglected, dehydrated and hungry</p>	<ul style="list-style-type: none"> • Is neglect ongoing? • Appropriate referral to community services • Is there a legal obligation to report to child protection authorities or state health department? 	<ul style="list-style-type: none"> • Immediate medical attention for children • Check file to see if it is a recurring event • Contact child protection agency • Develop care plans for children 	<ul style="list-style-type: none"> • Slur on community for not picking it up before • Housing options may not be appropriate • Possible lack of response from agencies 	<ul style="list-style-type: none"> • Community networks to promote care for children • Regular check-ups for children

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>There is an epidemic of violence within a family grouping and one woman keeps coming to the health service with marks on her body</p>	<ul style="list-style-type: none"> • Support and counselling needs for the women • Effects on children and parents • Confidentiality of case notes • Immediate safety needs, including accommodation • Should the matter be referred to the police? 	<ul style="list-style-type: none"> • Review file notes • Immediate medical attention and counselling • Contact police liaison officer • Referral to visiting magistrate 	<ul style="list-style-type: none"> • Withdrawal of statement by women • Fear of police/medical attention • Withdrawal of restraining order or charges 	<ul style="list-style-type: none"> • Enlist community support • Create a safety net through cooperation and coordination with police and other community organisations
<p>A client attempts suicide</p>	<ul style="list-style-type: none"> • Extent of injuries • Need for psychological assessment • History of mental illness 	<ul style="list-style-type: none"> • Immediate medical attention and counselling • Reduce access to means of self-harm (eg firearms, medications) 	<ul style="list-style-type: none"> • Family or social instability • Lack of social support • Mental health problems 	<ul style="list-style-type: none"> • Assess client for signs of depression/distress in future consultations (see Tool 3) • Provide ongoing management and/or refer to specialist services • Enlist community support

Identifying options for responding to incidents and overcoming barriers

The table below may be useful in helping you to identify scenarios that are common in your community or health service, and to think through options for responses.

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers

FURTHER RESOURCES

Supplementary information to this chapter can be found in:

- Tool 1 – How you can recognise the different types of violence
- Tool 2 – How you can manage anger and aggression
- Tool 3 – How you can document the effects of violence
- Tool 6 – How your community can become safer

Publications

Title	Description	Reference
Books		
<i>PREVENT – Promoting Rural Empowerment: Violence Education and National Training</i>	A six-module kit on domestic violence with videos and overheads. Takes a community development approach	Domestic Violence Regional Service (South West) Inc (1998)
<i>Preventing Client-Related Violence: A Practical Handbook</i>	A comprehensive approach to preventing client-initiated violence	Mayhew (2000a)
Domestic and family violence		
<i>Guidelines for Developing Protocols on Intervention and Management of Family and Domestic Violence for Hospitals in Western Australia</i>	Comprehensive guidelines on health policy, definition, identification and intervention in family and domestic violence. See Resource Manual below.	Eastern Perth Public & Community Health Unit WA (1998a) www.health.wa.gov.au/Publications/dovigui.pdf
<i>Accompanying Resource Manual for Family and Domestic Violence Protocols for Hospitals in Western Australia</i>	A set of protocols relating to handling violence in WA hospitals, including monitoring and staff development	Eastern Perth Public & Community Health Unit WA (1998b) www.health.wa.gov.au/Publications/dovires.pdf
<i>Responding to Family Violence, a Guide for Health Care Workers in Western Australia</i>		Eastern Perth Public and Community Health Unit (2001) www.health.wa.gov.au/Publications/RespondingtoFDV.pdf
<i>Is Domestic Violence too Close to Home? A Kit for Rural Women</i>	Outlines impact of domestic violence and safety measures. Provides legal and support services contact numbers in each state/territory	Lodden-Mallee Women's Health (1997)

Title	Description	Reference
<i>National Rural Domestic Violence Information Kit</i>	Includes information on supporting victims and on services available to victims of domestic violence	OSW (1998)
<i>Women and Violence</i>	Provides detailed information about violence against women.	RACGP (1998)
<i>Domestic Violence and Health Care: What Every Professional Needs to Know</i>	Describes evidence collection and safety protocols for health care workers who deal with domestic violence	Schornstein (1997)
<i>Domestic Violence in Regional Australia: A Literature Review</i>		WESNET (2000)
<i>Domestic Violence Education: A Learning Package Prepared Specifically for Health Workers in Rural Areas</i>	A learning package on domestic violence for rural health care workers.	Woolley (1994a)
Child abuse		
<i>Child Protection and Families: a Training Kit for Family Workers</i>	A 19 unit kit on a wide range of child protection issues and strategies	Elliot (1991)
Aboriginal and Torres Strait Islander peoples		
<i>A Medical Practitioner's Guide to Aboriginal Health</i>	Introductory guide for medical practitioners providing services to Indigenous communities	AMA (WA) & Healthway (1998)
<i>Binan Goonj – Bridging Cultures in Aboriginal Health</i>		Eckermann et al (1992)

Title	Description	Reference
Journal articles		
Violence against women: an education program for community health workers.		Anderson et al (1997)
The impact of domestic violence on individuals.		Astbury et al (2000)
'A little encouragement': health services and domestic violence.		Bates et al (2001)
Child sexual abuse protocols: an evaluation.		Collingridge (1997)
Community health workers' response to violence against women.		Davies et al (1996)
The road to freedom: ending violence against women.		Harris et al (1997)
Domestic violence in Australia: definition, prevalence and nature of presentation in clinical practice.		Hegarty et al (2000)
Dealing with cases of child sexual assault: some guidelines for health workers.		Kennedy (1991)
Dealing with cases of child sexual assault: some guidelines for health workers.		Kennedy M (1991)
What can we do about domestic violence?		Mazza et al (2000)
Evaluation of a self-paced education package on violence against women for rural community-based health workers.		McCosker et al (1999)
Domestic violence.		Raphael (2000)
The perpetrators of domestic violence.		Romans et al (2000)

Note: Full publication details are given in the Bibliography (see page 83).

Websites

The following websites provide detailed information that may assist you in developing your own responses or providing further information to clients. You may also be able to find resources by searching the website of the health department in your state/territory.

Organisation	Website address (URL)
<i>Domestic violence</i>	
Australian Domestic and Family Violence Clearing House	www.austdvclearinghouse.unsw.edu.au
Domestic Violence Prevention Unit (WA)	www.wa.gov.au/wpdo/dvpu/contacts.html
Office of the Status of Women	www.osw.dpmc.gov.au
Partnerships Against Domestic Violence	www.padv.dpmc.gov.au
Relationships Australia	www.relationships.com.au
Women Tasmania	www.women.tas.gov.au
Women's information and referral service	www.wire.org.au
Women's Services Network	www.wesnet.org.au
<i>Sexual assault</i>	
Centres Against Sexual Assault (Vic)	www.northern.casa.org.au/casar.htm
Sexual Assault Services (Qld)	www.health.qld.gov.au/violence/sexual/services.htm
Sexual Assault Referral Centre (NT)	www.nt.gov.au/nths/comm_svs/facs/sarc/sarc.shtml
<i>Child abuse/child protection</i>	
Australians Against Child Abuse	www.aaca.com.au/aserv/18.htm
Barnardos	www.barnardos.org.au/frserv.htm
BestStart Victoria	www.beststart.vic.gov.au/provider.htm
Child Safety Network of Australia	www.childsafe.net.au/
Kid's Helpline	www.kidshelp.com.au/
National Clearing House on Child Abuse	www.aifs.org.au/nch/nch_menu.html
<i>Young people</i>	
National Clearing House on Youth Studies	www.acys.utas.edu.au/ncys
Youth suicide support	home.vicnet.net.au/~chomp/contacts.html
<i>Aboriginal and Torres Strait Islanders</i>	
ATSIC	www.atsic.gov.au

Note: As websites are continually being updated, the web addresses (or URLs) included here are mostly the main addresses for each organisation rather than pages within the website. Once you have located the website, you can locate more specific information within the website using the site's search engine or directory.

If a web page cannot be displayed, it may be because the website has been reorganised. If you delete any text following a slash (eg change www.relationships.com.au/in_your_state/landing.asp to www.relationships.com.au), you should be able to locate the home page of the organisation. Otherwise, you may need to search the web for the organisation's site. General search engines that search the world wide web include:

- www.google.com
- www.yahoo.com.au
- www.altavista.com.au
- www.powerup.com.au

Counselling

To locate counselling services in your area, look in the government index of your local telephone book under *counselling* or under the relevant type of violence (eg *domestic violence, children*).

3 Caring for yourself⁵

Providing continuous and coordinated health care for individuals, families and communities can be a challenging and exhausting task for health care workers in rural and remote settings. As discussed, your role in the health service and within a small community may be very rewarding but invariably it is a demanding role and you will need to find ways to cope with the stress associated with rural and remote practice. The type of stress and ways of dealing with it will depend to some extent on the sort of work you are doing and whether you provide visiting services or live there permanently.

This chapter discusses ways in which you can avoid burn out and cope with traumatic stress and where you can get support.

3.1 MAINTAINING RESILIENCE AND AVOIDING BURN OUT

The high levels of day-to-day hassles and frustrations commonly associated with rural and remote practice, combined with the lack of anonymity and the 24-hour nature of the role can lead to health care workers existing in a chronically stressed state. High levels of stress over a long period of time can erode your resilience (ie the ability to 'bounce back') and eventually lead to burn out. It can also leave you vulnerable to the psychological impact of episodes of violence when they occur.

Taking positive action

As a health care worker in a rural or remote community, it is important that you accept responsibility for looking after yourself. Many health care workers make the mistake of always putting the needs of clients, communities and employers before their own. While this is necessary sometimes, the more exhausted and run down you become, the more vulnerable you will be to long-term psychological harm. Your ability to provide safe and appropriate care for clients may also be compromised.

Try to prioritise your work and set boundaries which allow you to preserve your well-being. This includes regular periods of rest and time out from your professional roles.

5. This chapter is based on material produced by the Council of Remote Area Nurses of Australia Inc (CRANA) Personal Support Network (Bush Crisis Line) as outlined in the section on further resources on page 38.

Positive actions to avoid burn out	
<p>Maintain resilience and well-being</p> <ul style="list-style-type: none"> • Maintain balanced lifestyle (work, rest and play) • Maintain good social support networks • Regular periods of rest or time out • Maintain a healthy lifestyle <p>Act on the situation</p> <ul style="list-style-type: none"> • Clarify your role and its boundaries • Clarify others' expectations of you • Have sufficient skills to deal with likely events • Identify sources of stress • Act to change stressors that can be changed • Learn to live with stressors that can't be changed • Develop good problem-solving skills 	<p>Be active about managing your stress response</p> <ul style="list-style-type: none"> • Accept responsibility for your well-being • Actively manage stress responses as they arise • Take a realistic view of human capabilities – prioritise, set realistic goals, and then set boundaries • See challenges as growth-producing experiences • Be optimistic – reframe, look for positives, reduce negative self talk • Keep a journal • Engage in critical reflection • Exercise • Meditate

Source: Kelly (2000)

Dealing with frustration and anger

Remote health care workers often have to deal with high levels of frustration, which can give rise to anger. Anger is a natural, healthy emotion that can help you to recognise when you or your well-being are at risk. However, in small team and community settings, uncontrolled anger can destroy relationships and erode the goodwill that you have built up. Reacting angrily often only makes the situation worse.

Tool 2 outlines some strategies to help you manage your anger.

3.2 TRAUMATIC STRESS

'Traumatic events' are those which involve threatened or actual death or serious injury, to yourself or others. Exposure to any form of violence has the potential to traumatise health care workers. This includes homicides, suicides, family and domestic violence, physical and sexual assaults, home invasion, stalking and threats of violence.

Reactions to job-related traumatic events, including violence, can vary greatly. How you interpret the event will have an effect on your experience of the event and its impact upon you (Raphael & Wilson 1993). For example several health care workers exposed to the same event might react quite differently, with one finding it ordinarily stressful, one experiencing it as an opportunity to use skills under pressure, and another feeling overwhelmed and traumatised.

Indicators of traumatic stress

During the event	After the event
<ul style="list-style-type: none"> • Intense feelings of fear, horror and/or helplessness • Feeling unreal, numb, in a daze, outside of self looking on • Time becomes distorted • Disorientation to time and place 	<ul style="list-style-type: none"> • Strong feelings of distress and anxiety • Sleep disturbances (including nightmares) • Wanting to avoid memories or reminders of the event • Flashbacks or unwanted thoughts • Feeling emotionally numb or empty • No joy from previously joyful events or circumstances

Source: Kelly (2000)

It is important to remember that traumatic stress reactions are normal human reactions to extremely difficult experiences. Reactions can be mild or strong and may last for hours, days or weeks (although they usually start to settle after the first week or so). Reactions tend to have a cyclical effect where periods of intense memories and feelings associated with the event alternate with periods of numbness.

Health care workers tend to put their feelings on hold in order to respond appropriately in emergencies. This increases the likelihood of their reactions to the event being delayed. You may find that you do not react to the event until you feel safe enough to allow yourself to feel your feelings. For some people this may not be until they have cleaned up and gone home, for others it may be when they go off call, and others may not feel the impact until they are on days off. Some reactions can be delayed for weeks or months and may take workers by surprise when they occur.

3.3 WHERE CAN YOU GET SUPPORT?

Support within the workplace

Your employer is obliged to provide a safe workplace and to protect your well-being. This should include the prevention of violent events where possible, the provision of skills to manage predictable violent events, stress management training, and a supportive organisational environment which recognises and validates your responses to difficult situations and facilitates recovery and early referral. The obligations of employers are further discussed in Chapter 4.

As a health care worker, you share responsibility for your own safety within the scope of your control and authority. You must comply with safe work practices and have a responsibility to not put yourself at risk of harm. If you have been physically or psychologically harmed in the course of your employment, you have a right to submit a workers' compensation claim to your employer for that injury.

Support from other community services

While you may not have ready access to community services or even the police as points for referral during an episode of violence, it is important that you don't bear the brunt of violent episodes alone. Wherever possible, you need to be able to refer violent situations to others who are better trained to deal with them, and be able to obtain support, at least by phone, while you are waiting for help to arrive. The health service needs to work in partnership with other community services and organisations, setting up networks for referral and strategies to overcome problems of access.

Psychological support

Sources of psychological support for health care workers include:

- employee assistance services (contracted by employers to provide employees with psychological support)
- Bush Crisis Line (see below)
- visiting mental health services
- visiting medical officers
- family and friends.

The Bush Crisis Line

The CRANA Personal Support Network (Bush Crisis Line) aims to support multidisciplinary remote health care workers and their families to maintain their well-being by effectively managing the stress associated with remote practice. This includes the provision of the 24-hour Bush Crisis Line, a confidential telephone debriefing and counselling service, which is available to all rural and remote health care workers and their families. This includes health workers, nurses, doctors, allied health professionals, managers and project workers.

The Bush Crisis Line is staffed by qualified psychologists with remote and cross-cultural experience. Support is available from Indigenous Co-counsellors if Indigenous health care workers require or request this.

A call to the Bush Crisis Line is anonymous and free from anywhere in Australia – Call 1800 805 391

3.4 CHECKLIST FOR ACTION

Have you?	Yes	No
Taken positive steps to maximise your resilience and well-being?		
Learnt to recognise traumatic stress reactions that occur during and after an event?		
Become aware that traumatic events may also have repercussions across the community at many levels?		
Discussed with your employer their responsibility in helping you care for yourself?		
Identified sources of support for yourself should stressful or traumatic events occur? (See Further resources on page 38)		
If you have been the victim of violence, completed an incident report form? (See Tool 3)		
Reported the incident to police, occupational health and safety and other relevant authorities if required?		

SUMMARY TABLE

The following table sets out sample scenarios and some options for responding to violent episodes and overcoming barriers. You can use the table to help you think through what kind of responses might be appropriate in your community. These are just examples of the types of situations that may occur. You will need to assess your own situations and your responses will be influenced by local circumstances. A blank table is also provided. You may wish to make copies of the table and use them to record how you or your health service deals with incidents, so that you can refer back to them and gain an understanding of responses that have been effective in your community.

Scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
Health care worker becomes target of violent husband after helping abused family	<ul style="list-style-type: none"> Personal safety Safety of family Occupational health and safety issues Is perpetrator armed? Engage existing community support structures 	<ul style="list-style-type: none"> Refer to police Complete incident report Engage employer support 	<ul style="list-style-type: none"> Employer resistance Lack of processes for ensuring safety / evacuation Lack of processes for continuing support / counselling Lack of community response process 	<ul style="list-style-type: none"> Employer has a responsibility to protect worker Do not attend alone in domestic violence situations Develop processes for ensuring safety / evacuation Seek counselling to avoid post-traumatic stress disorder Engage existing community support structures
Client dies as a result of violence despite best efforts of health care worker	<ul style="list-style-type: none"> Self and community blame for death and for not preventing death May undermine confidence in clinical skill 	<ul style="list-style-type: none"> Clear understanding of where responsibility for death lies Debrief re management of scenario 	<ul style="list-style-type: none"> No-one to debrief with Feelings of responsibility 	<ul style="list-style-type: none"> Develop peer support and supervision network Employer to implement Employee Assistance Program

Scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>Within one week, 16 children are flown to hospital with dehydration and two families are angry with the health care worker</p>	<ul style="list-style-type: none"> Whose responsibility/problem? What is the cause of the anger? Separation anxiety Cause of dehydration (eg heatwave, infectious illness) Was there a legal obligation to report the incidents to the appropriate child protection authorities? If so, has this been done? 	<ul style="list-style-type: none"> Try to establish responsibility/cause of anger Keep parents informed and in touch with their children and hospital health care workers 	<ul style="list-style-type: none"> Lack of physical facilities to cope with extreme heat Lack of community education on health and hygiene 	<ul style="list-style-type: none"> Prevention strategy Community education about dehydration in children Community effort to improve physical facilities
<p>A woman with a mental health condition comes into the clinic making accusations about a fellow health care worker</p>	<ul style="list-style-type: none"> Are the accusations possible or probable? Need to refer to appropriate mental health authority? 	<ul style="list-style-type: none"> Separate client and health care worker while matter is settled Discuss the situation with accused health care worker Determine propriety of making a decision Perform a mental health assessment and review treatment plan/compliance of client Complete report for complaints process 	<ul style="list-style-type: none"> Possible conflict between professional obligation to client and relationship with colleague 	<ul style="list-style-type: none"> Develop clear policies within organisation to apply in this situation – all staff must understand the need for reporting and that investigation may be necessary Clear understanding of duty of care to clients

Scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
GP in single doctor remote practice is feeling stressed and unable to cope	<ul style="list-style-type: none"> Is there someone to turn to for support (peers, manager/ employer, family, friends)? What are the sources of stress and can they be changed? 	<ul style="list-style-type: none"> Talk to another GP or health care worker (can be outside community) Contact Bush Crisis Line or Rural Doctors' Network Try to take time off (organise locum) 	<ul style="list-style-type: none"> Lack of anonymity Can be hard for those outside the situation to understand 	<ul style="list-style-type: none"> Develop a support mechanism with peers Discuss the situation with your employing agency Actively manage stress responses as they arise Consider contacting mental health service for assessment
An angry client is outside the building, hitting the health service's car with a baseball bat	<ul style="list-style-type: none"> Fear for safety of those in the clinic Is the person getting rid of their aggression on the car – or is this a precursor of a personal attack? Is this a precursor of escalating violence? Need to refer to police? 	<ul style="list-style-type: none"> Call police or other emergency service for back up Keep clear until the episode is over 	<ul style="list-style-type: none"> Fear for safety of self and others Responsibility/desire to protect property 	<ul style="list-style-type: none"> Keep staff and clients safe Identify safe area in clinic to hide in these situations Enlist community support to defuse the situation and prevent it getting worse Complete an incident report form

Identifying options for responding to incidents and overcoming barriers

The table below may be useful in helping you to identify scenarios that are common in your community or health service, and to think through options for responses.

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers

FURTHER RESOURCES

Supplementary material to this chapter is provided in:

- Tool 1 – How you can recognise the different types of violence
- Tool 2 – How you can manage anger and aggression
- Tool 3 – How you can document the effects of violence

Publications

Title	Description	Reference
CRANA Personal Support Network		
The following publications have been developed by the CRANA Personal Support Network (Bush Crisis Line) and are available through the CRANA office in Alice Springs (08 8953 5244) or from the CRANA website.		
<i>Preventing Job Related Posttraumatic Stress Disorder in the Remote Health Workplace: An Overview of the Evidence</i>	These companion papers were developed to assist managers and mental health practitioners to provide appropriate support to health care workers following job-related trauma. They include a review of the literature, a risk assessment tool and recommendations for nature and content of individual, team and community support interventions following job-related traumatic events in small communities.	Kelly (1999a)
<i>Preventing Job Related Posttraumatic Stress Disorder in the Remote Health Workplace: Best Practice Guidelines</i>	Documents some of the sources of stress associated with remote practice which, while shared across the professions, are preventable	Kelly (1999b)
<i>Preventable Sources of Occupational Stress in the Remote Workplace</i>	Developed to assist health care workers to self-manage their reactions to job-related traumatic events	Kelly (1999c)
<i>Surviving Traumatic Stress: A Guide for Remote Practitioners and Their Families</i>	Aims to assist health care workers to manage some of the unavoidable sources of stress associated with remote practice	Kelly (1999d)
<i>Avoiding Burn-Out in Remote Areas. Surviving the Day to Day Hassles: A Guide For Remote Health Practitioners</i>		Kelly (2000)

Note: Full publication details are given in the Bibliography (see page 83).

Counselling

To locate counselling services in your area, look in the government index of your local telephone book under *counselling* or under the relevant type of violence (eg *domestic violence, children*).

Just ask

Just ask is Lifeline's rural mental health information service. It provides information and referral for people with mental health problems, and to friends, relatives and others who want to know how to help. Information is provided about relevant local services, as well as books and websites. Just ask is not a counselling service, but an information service.

Phone **1300 13 11 14** Monday to Friday between 9am and 5pm or contact justask@lifeline.org.au or visit the lifeline website at www.lifeline.org.au.

Centrelink

Centrelink has established a number of new Centres in areas assessed as being 'high need'. These include areas considered to have a relatively high incidence of violence. Service provision is focused on presenting clients but Centrelink staff are expected to collaborate with other service providers.

Websites

The following websites may be useful in developing your own support or referral network. You may also be able to find resources by searching the website of the health department in your state/territory.

Organisation	Website address (URL)*
CRANA	www.crana.org.au
Australian Nursing Federation	www.anf.org.au
Nursing World	www.nursingworld.org/dlwa/osh/wp5.htm
Rural Doctors' Network	www.nswrdn.com.au/site/
National Rural Health Alliance	www.ruralhealth.org.au
Australian Medical Association	www.ama.com.au
Crime, police and emergency services	www.sjc.uq.edu.au/ozguide/crime.html

* See notes about locating websites on page 27.

4 Caring for the health service

Previous chapters have discussed the difficulties and dangers of rural and remote health practice and how these can combine to produce higher levels of stress than those experienced by health care workers in urban settings. The combination of high levels of violence in the community and high levels of stress within the workplace mean that a safety net needs to be in place to protect workers from violent episodes and their aftermath. As a manager or employer, you have an obligation under occupational health and safety legislation to ensure the workplace health and safety of workers and to provide a healthy and safe work environment. Your duty of care may extend to places and settings where a worker attends a client in the course of their employment.

This chapter discusses how you can meet this obligation by developing and implementing processes to prevent violence and harm to workers as far as possible by:

- recognising the impact of the threat of violence on well-being
- preparing for violent episodes through:
 - development of mechanisms for consulting with staff on occupational health and safety matters
 - provision of training to ensure that health care workers have the skills and knowledge needed to address violence in the workplace
 - ensuring that documentation procedures are in place in your organisation
 - considering occupational violence when designing, altering or extending premises
- taking a risk management approach (see Section 4.3)
- minimising the impact of violent episodes through planned responses (see Section 4.4)
- providing for recovery and review (see Section 4.5).

4.1 WHAT IS OCCUPATIONAL VIOLENCE?

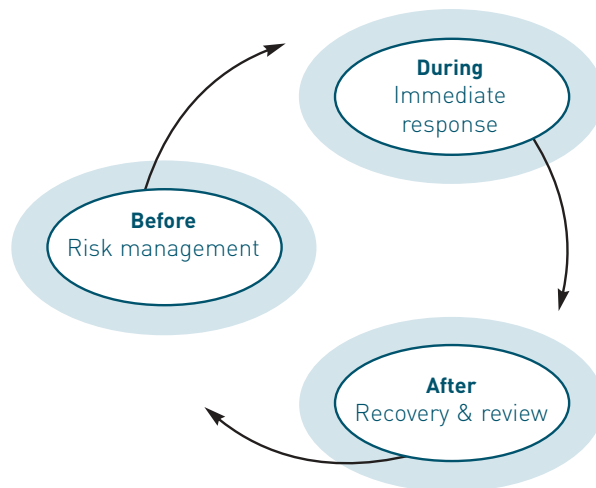
Occupational violence is 'the attempted or actual exercise by a person of any force so as to cause injury to a worker, including any threatening statement or behaviour which gives a worker reasonable cause to believe he or she is at risk' (NOHSC 1999). Just like violence in the general community, occupational violence can take many forms (CAL/OHSA 1998):

- internal to organisation – violence between employees, and between employees and managers or employers (eg bullying of a junior staff member by a senior manager; conflict between workers)
- client-related – violence between workers and clients (eg verbal and physical abuse of a health care worker by a client during a consultation)
- random acts of violence – incidents perpetrated by members of the public (eg threats to a health care worker on the premises; damage to a health care facility with a consequent negative impact upon workers and employer) (Muller 1997; Mayhew 2000b).

As well as physical violence, violence in the workplace includes non-physical violence such as verbal abuse, stalking and threats of physical violence. Different types of violence are described in Tool 1.

4.2 PREPARING FOR VIOLENCE

Violence should never be accepted as 'just part of the job'. It must be assessed and controlled in the same way that other hazards in the workplace are managed. The three phases of managing occupational violence – planning and implementation of risk management strategies, immediate response to a violent episode, and recovery and review – correspond to 'before, during and after' the violent episode. The three phases represent a cyclic approach. The figure below shows how the phases can inform the actions in following phases to promote continuous improvement through experience.



To support measures to prevent occupational violence and reduce its impact on the workplace, there needs to be commitment by both managers and employees to action in a range of areas. Within the context of a risk-management approach (see Section 4.3), there should be ongoing training in managing violent situations and systems in place for managing information about violent incidents.

Commitment from managers

Manager commitment to the health and safety of workers is an obligation imposed through workplace health and safety legislation. You can show your commitment to addressing violence in the workplace by providing leadership, motivation and access to resources. While there are many ways to become actively involved, adopting and supporting organisational mechanisms (eg a policy on occupational violence and procedures to support its implementation) show that you are concerned about the problem and about employee well-being. If there are not enough people locally to develop processes for addressing violence, networks of smaller services (either geographic or organisational) can be formed for developing policies and mechanisms for monitoring.

The checklist provided in Section 4.6 outlines ways in which you can make a difference to the management of violence within your organisation. The discussion of policy development in Tool 4 is provided as a starting point for the development of objectives and processes suitable to your health service.

Active worker participation

As it is the frontline workers who face the risk of violence, their active participation in the planning, implementation and evaluation of occupational violence-related initiatives is critical to success. Participation is in the best interests of these workers and provides them with opportunities to better understand occupational violence, contribute their knowledge and experiences to how the risk of occupational violence should be managed and provide ongoing feedback on measures that are implemented. As an employer or manager you may encourage employee involvement through the legislative occupational health and safety consultative mechanisms such as the workplace health and safety committee, workplace health and safety representative and officer roles.

Safety and health training and education

Staff training and education in safety issues should be one of a suite of strategies to address violence in the workplace. This ensures that all staff members are informed of potential hazards and know of, and have been trained in, the appropriate actions to protect themselves and their fellow workers. Before a potential staff member accepts an appointment, he or she should be given information to help them prepare for the realities of the position they are taking up, including the incidence of violent episodes, the working conditions and expected levels of support.

Training in appropriate procedures should be provided as part of orientation programs for new employees as well as on a yearly update/refresher basis for existing health care workers. The training that is required will be determined by the hazards that have been identified through the risk management process [CAL/OSHA 1998].

Information systems

Consistent reporting of violent incidents helps to provide information on the frequency and severity of violence within your health service and the types of actions that are useful in reducing violence. Records may be accessed as a legal account of reported incidents or for specific purposes such as workers' compensation/rehabilitation or insurance if a worker has been the injured party. They can also help you to identify training needs and opportunities to improve the management of violence in your organisation.

It is therefore essential that documentation procedures are in place in your organisation and that all incidents are appropriately recorded and reported to the relevant authority. The task of reporting may be delegated to local clinic level where managers are located distantly. Incident report forms should be readily available wherever health care workers may be located – for example, desks, cars and homes. Feedback systems should also be in place so that employees and new or potential staff members are aware of trends in the workplace, implemented management strategies and the outcomes of the strategies (CAL/OSHA 1998).

In many states of Australia, it is a legislative requirement for employers to keep records of work-related injuries, illnesses and dangerous events or near misses. If you are unsure of your legal obligations you should contact the state or territory agency responsible for workplace health and safety (see the section on *Further resources* at the end of this chapter).

Tool 3 includes an incident report form that can be photocopied for use or adapted so that it is suitable to your context.

Safer by design

The prevention and management of occupational violence should be a consideration when health care premises are designed, altered or extended. Changing or managing the workplace environment can reduce the incidence of violent episodes as well as creating an environment that workers perceive as safe and meeting relevant national standards. This may include restricted access to certain areas, use of locks on storage areas, designated 'safe' escape rooms (with telephone or duress alarm), and fitting of duress alarms in all rooms of the health service. Workers making community visits can be issued with mobile phones or personal alarms or, where possible, work in pairs. Detailed call-in check systems and pre-planned distress messages are also useful ways to protect staff working outside the workplace (Mayhew & Chappell 2001b).

4.3 RISK MANAGEMENT

The process of risk management is required as standard practice for the control of hazards in Australian workplaces. A structured and ongoing risk management process in the workplace is a key element of an employer's demonstrated commitment to ensuring the health and safety of workers. Taking a risk management approach to providing a safer working environment for health care workers is also a sound cost-benefit strategy, when the costs associated with high turnover of staff and the potential for occupational health and safety claims are considered.

The process of risk management comprises the following steps (Queensland DETIR 2000):

- identification of hazards
- assessment of risk associated with the hazard
- decision on what risk control measures will be implemented
- implementation of control measures
- monitoring and review of the effectiveness of the measures.

In determining whether and how a hazard should be managed, it is important to follow a structured and transparent system to assess both the risk associated with the hazard and the most appropriate measures to eliminate or control it. The chosen measures should be strongly connected with the hazards that have been identified.

If your workplace is not following a risk management approach to worker health and safety, it might be useful to contact the state or territory agency responsible for workplace health and safety to discuss your obligations (see *Further resources* at the end of this chapter).

Tool 5 discusses the process of risk management in greater detail and includes forms to guide you in keeping a record of your actions.

Hazard identification

A systematic, commonsense examination of your workplace and work-related procedures will help you to identify the situations, causes and factors that place workers at risk. This is an important step in managing the risk of harm to workers. In rural and remote areas, the process of hazard identification is often more complex than in urban settings, as a wider range of scenarios and settings needs to be included in the process.

Risk assessment

In the process of hazard identification, you may identify only a few hazards or have quite a long list. Whatever the case, as you don't have unlimited resources (financial, time or human), you will need to work out which of the identified hazards should have highest priority. Risk assessment involves considering the risk associated with identified hazards, so that you can determine priorities to guide action for risk control.

Risk control – determining and implementing appropriate measures

Once the hazards have been identified and the associated risk of harm estimated, appropriate actions can be determined and initiated. It may be possible to control an identified hazard in a number of different ways. However, several complementary actions may be required to effectively reduce the level of risk. It is important that the measures you select are well matched to the circumstances of your workplace and work processes.

Monitoring and review

The process of risk management is not a one-off event. Workplaces evolve and change over time in response to external and internal factors. It is important to regularly monitor the workplace and review the interventions that have been implemented to determine their ongoing effectiveness. It is also necessary to assess barriers to effectively managing risks and find ways to overcome them. Following an incident, review of the interventions that have been implemented should be undertaken to determine the ongoing effectiveness of control measures and immediate responses (CAL/OSHA 1998; Worksafe WA 1999).

4.4 IMMEDIATE RESPONSE TO VIOLENT EPISODES

An effective immediate response to a violent incident should control and defuse the situation and reduce the risk of long-term psychological harm for employees at all levels. When an incident occurs, ideally the planning that has gone into managing violence in the workplace should result in a well-coordinated response, with agreed procedures followed in accordance with the training provided.

The immediate response to violent episodes includes following procedures for:

- minimising the risk of harm to employees – this may include moving to an allocated safe place which has phone facilities, controlling media access to employees, facilitating communication with families and arranging transport home if feasible
- incident reporting (see Section 4.2 and Tool 3)
- referral to appropriate community agencies (eg police, mental health services)
- containing and, where practical, defusing situations until referral agencies can respond.

When violent incidents occur, employees should know what to do and who has the authority to take charge of the situation. That person should have had training in how to coordinate the response, including taking care of employees who may be injured, in shock or affected by the incident in other ways.

4.5 RECOVERY AND REVIEW

Following violent episodes, reorganisation and reconstruction may be needed to return the workplace to normal operations. At this point the situation should be under control – the health service should already have been made safe, first aid and medical assistance arranged as necessary and immediate support provided for affected employees.

In the recovery phase, plans previously agreed upon should be implemented as quickly and efficiently as possible to reduce the risk of long-term problems. The following actions should be part of the process:

- providing clear information to all employees
- providing ongoing professional counselling and support services for employees and their families
- responding appropriately to workers who have been the perpetrator of violence (eg through removal and counselling)
- allowing employees time to recover (including, where possible, change of location or increasing staff to allow for recovery) but encouraging early return to work as part of the recovery process
- providing assistance and ensuring that workers have access to advice on legal matters and workers' compensation arrangements as appropriate
- investigating the incident and reviewing safety management to reduce the risk of injury or harm in the future.

Exposure to trauma

Occupational violence programs should provide comprehensive treatment for employees who may be traumatised by experiencing or witnessing a violent incident. Following the event, recovery of health care workers in rural and remote settings may be compromised by (Kelly 1999a):

- limited opportunities for time out to appraise the impact of the event
- lack of control over rest or recovery time
- inability to bring 'closure' to the event (eg prolonged investigations)
- the community-wide impact of the event coupled with lack of natural circuit breakers between home and work
- any blame or retribution directed at the health care worker
- worker dissatisfaction with their role during the event (eg guilt or shame)
- confidentiality issues (such as risks to their personal and professional standing).

While some traumatic events can result in long-term problems, most can be effectively managed using human resource management strategies without resulting in ongoing problems (Toohey 1996). Lack of adequate management support following work-related traumatic events has been shown to complicate staff recovery processes, intensify reactions and prolong reactivity and to generate higher costs from absenteeism, turnover, performance decline, treatment and compensation (Paton 1997).

Support services to facilitate recovery following exposure to violent events can be provided at a number of levels. These include the provision of information, help lines (such as the Bush Crisis Line), access to employee assistance programs and supportive management of work-related traumatic events, including on-site interventions for individuals, teams and communities if this is required.

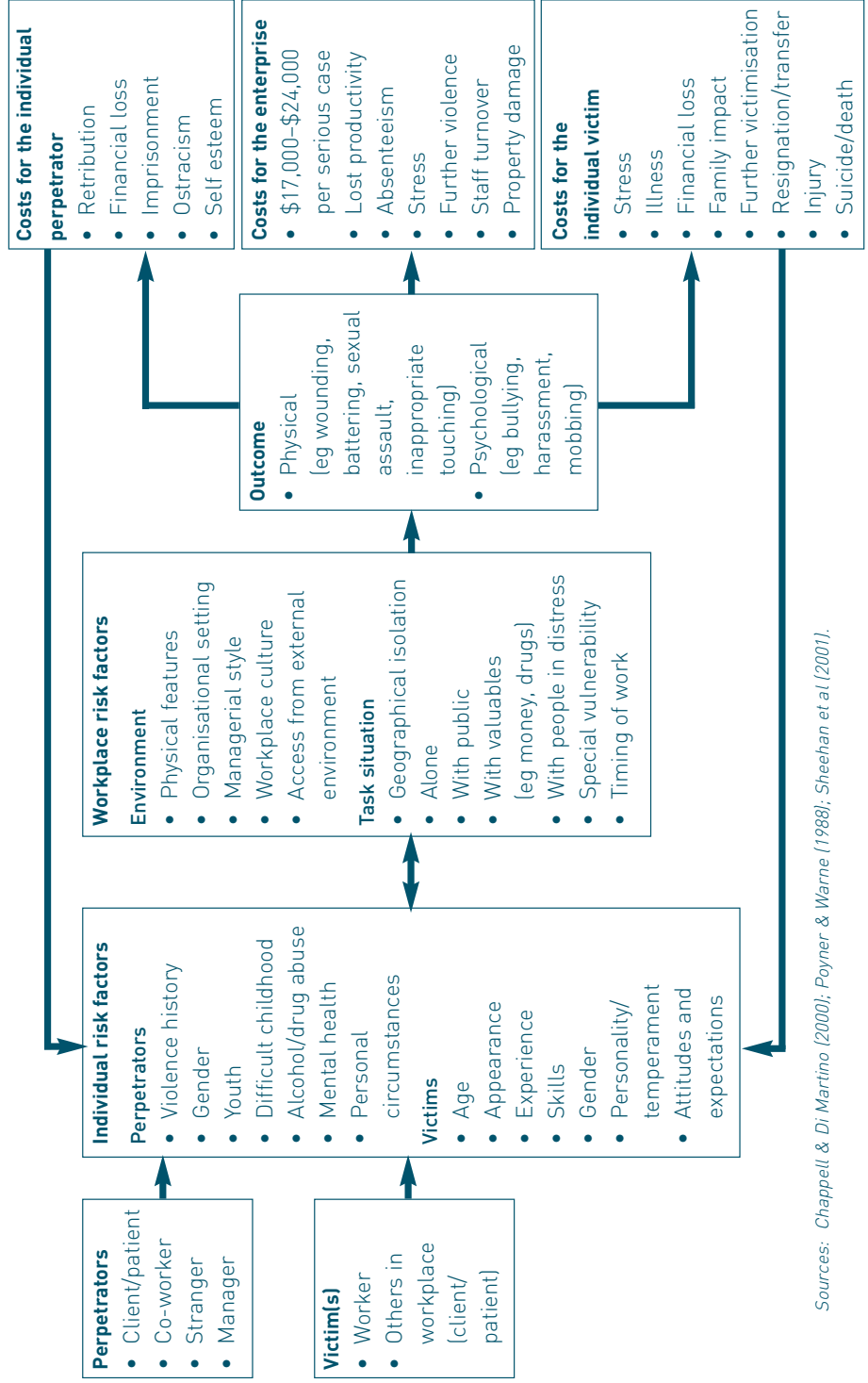
Debriefing interventions should be carried out by an experienced mental health worker on a one-to-one basis so that confidentiality can be maintained (Kelly 1999a). Additional support should focus on building on existing strengths, activation of social support networks, education about the likely effects of trauma, promotion of and education about positive coping strategies, and when and where to seek specialised assistance if required. Debriefing to meet the needs of Indigenous health workers affected by violent events should be carried out in collaboration with Indigenous colleagues.

While psychological support and debriefing interventions should be offered, attendance should not be compulsory for health care workers. It should also be remembered that debriefing interventions are not a one-off or cure all process, and the support, monitoring, and intervention needs of those exposed to trauma will continue for some time. Following the initial intervention, support should remain available for the duration of the recovery process.

Maximising recovery post job-related traumatic events such as violence is a mutual responsibility. Where support is provided, the health care worker has a responsibility to access this if they are experiencing difficulties.

Occupational violence: an interactive model

Occupational violence is a complex issue, resulting from interactions between individuals, their environment and the organisation. This model shows the factors and interactions that may lead to occupational violence and may be of use in analysing situations in your workplace.



4.6 CHECKLIST FOR ACTION

Have you?	Yes	No
Become aware of indicators of stress, physical and psychological abuse? (See Tool 1)		
Prepared for episodes of violence by developing a policy on occupational violence and procedures that help prevent violence in the workplace, maintain well-being of employees and minimise the impact of violent events through planned responses (see Tool 4)?		
Worked with employees to address occupational violence by providing leadership, motivation and access to resources?		
Developed a system of orientation and ongoing training for employees in safety issues so that they are informed of potential hazards and equipped to take appropriate actions to protect themselves and fellow workers?		
Developed systems for recording and analysis of work-related injuries, illness and dangerous events or near misses (see Tool 3)?		
Developed a risk-management approach in your organisation and kept records to show that you have been actively working to ensure workplace health and safety (see Tool 5)?		
Identified and/or prepared a secure area within the building with phone facilities and provided safety systems (eg separate entrances, call buttons in clinic rooms, doors, security etc) to reduce risk of harm to workers?		
In the event of an episode where physical or psychological harm occurs to workers, met occupational health and safety obligations (as required in your state/territory) such as incident reporting?		
Developed procedures for recovery and review, including appropriate counselling for traumatised workers?		
Checked that policies and procedures are developed in line with relevant national and state/territory legislative requirements?		
Checked that relevant national and state/territory legislative requirements are incorporated into procedures where appropriate?		

SUMMARY TABLE

The following table sets out sample scenarios and some options for responding to violent episodes and overcoming barriers. You can use the table to help you think through what kind of responses might be appropriate in your community. These are just examples of the types of situations that may occur. You will need to assess your own situations and your responses will be influenced by local circumstances. A blank table is also provided. You may wish to make copies of the table and use them to record how you or your health service deals with incidents, so that you can refer back to them and gain an understanding of responses that have been effective in your community.

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
Health care worker subjected to repeated acts of minor violence (kicking, shoving) by senior staff member	<ul style="list-style-type: none"> • Worker safety • Safety of other workers • Service provision • Workforce morale • Legal implications • Disciplinary and performance issues 	<ul style="list-style-type: none"> • Worker reports incidents to employer • Worker seeks peer or outside support (eg bush crisis line) • Employer confronts perpetrator • Incident reporting 	<ul style="list-style-type: none"> • Perpetrator may be employer • Employer denial of situation • Lack of mission statement or policies • Worker may not report due to fear of losing job or retribution 	<ul style="list-style-type: none"> • In cooperation with employees, develop policies and mission statement and procedures for reporting such incidents and encourage active reporting • Develop orientation and ongoing staff training on occupational violence • Provide counselling for perpetrator and worker

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>A client becomes increasingly agitated during a consultation leading to threats about the health care worker's personal safety</p>	<ul style="list-style-type: none"> • Worker safety • De-escalation skills • Availability of back-up • Ongoing welfare of worker • Is it appropriate to refer the matter to the police? 	<ul style="list-style-type: none"> • Worker calls for assistance • Worker de-escalates violence (see Tool 3) • Note made on client file about the behaviour • Provide support to worker • Ensure ongoing safety for worker and client • Provide counselling/debriefing to worker 	<ul style="list-style-type: none"> • Lack of training in de-escalation skills • No back-up available • No safety equipment (eg duress alarms) available to workers 	<ul style="list-style-type: none"> • Provide training in de-escalation • Develop locally relevant policy for back-up • Prepare workplace so that harm to workers is minimised • Develop procedures and a system for identification of high risk clients
<p>During a risk assessment session it is found that many staff did not know what to do during a recent critical incident</p>	<ul style="list-style-type: none"> • Is there a policy on responding to a critical incident? • Are safety issues included in orientation and ongoing training? 		<ul style="list-style-type: none"> • Lack of policy on incident management • Staff availability for training • High staff turnover 	<ul style="list-style-type: none"> • Develop policy on incident management • Develop orientation and ongoing staff training on occupational violence

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>A manager refuses to acknowledge the fact that a health care worker was nearly raped during a community visit</p>	<ul style="list-style-type: none"> • Is the risk to the worker ongoing? • Is support available for the worker? • Are other workers exposed? • Has the assault been referred to the police? • Is there a legal obligation to complete an incident report form? 	<ul style="list-style-type: none"> • Support provided to worker • Worker seeks support from peers or outside agency • Complete incident report form and note on client's file • Check original incident was referred to the police 	<ul style="list-style-type: none"> • Ongoing denial of manager • Lack of procedures for incident reporting 	<ul style="list-style-type: none"> • Identify and address staff training needs (at all levels) • Develop orientation and ongoing staff training on occupational violence • Develop safety procedures for visits (eg carrying of duress alarms) and procedures for incident reporting • Develop local peer support network
<p>A health care worker often works alone at night in insecure premises</p>	<ul style="list-style-type: none"> • The community's need for a health service • Legal obligations placed on employers to ensure safety of staff at work and others on premises • Duty of care owed by worker does not include putting oneself at risk 	<ul style="list-style-type: none"> • Secure premises and have access systems • Consider alarm or duress systems • Engage temporary security staff until premises are secured 	<ul style="list-style-type: none"> • Financial constraints • Police may be located distantly 	<ul style="list-style-type: none"> • Consider need for service in that setting at that time • Initiate measures to improve security of premises • Consider alternative local security options • Modify premises and provide equipment to ensure safety

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>A health care worker wakes up at home to find a client sitting on the end of the bed who wants to talk</p>	<ul style="list-style-type: none"> • Safety of worker and family • Availability of back-up • Security of premises • Is person known to health care worker? • Does he or she have a history of violence? • Is there a legal obligation to complete an incident report form? 	<ul style="list-style-type: none"> • Try to move client to a safer environment • Assess immediate risk to health worker and others • Call for back-up • De-escalate any anger or threat of violence (see Tool 3) 	<ul style="list-style-type: none"> • Client refuses to move • Security issues (eg no locks on door) • Lack of clear boundaries between personal and professional lives • Delays in arrival of back-up 	<ul style="list-style-type: none"> • Develop policy for back-up (outside of workplace) • Develop security procedures • Identify staff training needs • Improve security
<p>A health care worker is cornered in a room by a client having a psychiatric episode. He is pulling equipment off the shelf and the health care worker feels under threat</p>	<ul style="list-style-type: none"> • Safety of worker • Escape routes • Experience and de-escalation skills of worker • Availability of back-up 	<ul style="list-style-type: none"> • Remove to safer environment • Call for back-up if possible • De-escalation process (see Tool 3) • Seek specialist advice 	<ul style="list-style-type: none"> • Lack of procedures for back-up • Lack of experience and/or training • Poor design of premises • Access to specialist advice 	<ul style="list-style-type: none"> • Identify and address staff training needs • Develop policy for back-up • Improve clinic design and layout

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers
<p>A health care worker is contacted by the police to conduct the forensics in a sexual assault case for court action</p>	<ul style="list-style-type: none"> • What are the legal requirements? • Is the victim a child or adult? • Does the health care worker have the necessary skills? • Has consent been obtained? 	<ul style="list-style-type: none"> • Meet legal obligations 	<ul style="list-style-type: none"> • Lack of training • Assumptions on part of the police • Lack of knowledge of legal requirements 	<ul style="list-style-type: none"> • Develop procedures • Identify and address staff training needs • Clarify legal requirements • Clarify communications between police and health care workers

Identifying options for responding to incidents and overcoming barriers

The table below may be useful in helping you to identify scenarios that are common in your community or health service, and to think through options for responses.

Sample scenario	Considerations	Options for immediate responses	Barriers	Overcoming barriers

FURTHER RESOURCES

Supplementary material to this chapter is provided in:

- Tool 1 – How you can recognise the different types of violence
- Tool 3 – How you can document the effects of violence
- Tool 4 – How you can develop and implement a policy on occupational violence
- Tool 5 – How you can include occupational violence in your risk management process

Occupational health and safety and compensation authorities

The occupational health and safety and workers' compensation authorities in each state and territory can be contacted for information on the actual requirements of their occupational health and safety and workers' compensation laws (see under state/territory Government Agencies in your local telephone book). Comcare Australia administers occupational health and safety and workers' compensation laws for those employed in the Commonwealth sector (see under Commonwealth Government Agencies in your local telephone book).

Publications

Title	Reference
<i>Guidelines for Security and Safety of Health Care and Community Service Workers</i>	CAL/OSHA (1998)
<i>Preventing Job Related Posttraumatic Stress Disorder in the Remote Health Workplace: An Overview of the Evidence</i>	CRANA (1999a)
<i>Preventing Job Related Posttraumatic Stress Disorder in the Remote Health Workplace: Best Practice Guidelines</i>	CRANA (1999b)
<i>Context of Silence: Violence and the Remote Area Nurse</i>	Fisher et al (1995)
<i>Occupational Violence: Types, Reporting, Patterns and Variations between Health Sectors</i>	Mayhew & Chappell (2001a)
<i>Prevention of Occupational Violence in the Health Workplace</i>	Mayhew & Chappell (2001b)
<i>Preventing Violence to Staff</i>	Poyner & Warne (1988)
<i>Workplace Health and Safety Risk Management Advisory Standard 2000</i>	Queensland DETIR (2000)

Note: Full publication details are given in the Bibliography (see page 83).

Websites

The websites of the national occupational health and safety and compensation authorities provide links to those of the states and territories. You may also be able to find resources more directly related to health services by searching the website of the health department in your state/territory.

Organisation	Website address (URL)*
National Occupational Health and Safety Commission	www.nohsc.gov.au
Compensation authorities	www.hwsca.org.au
Standards Australia	www.standards.com.au

* See notes about locating websites on page 27.

5 Working within the law

When incidents of violence occur, some form of follow-on has to take place. This may involve improving safety or responses locally (eg within the health service as discussed in Chapter 4). In some cases, legal action may be required. Reporting and other legal implications for health services will depend on the type of violence encountered. Legal obligations also vary across the states and territories. This chapter outlines:

- points about legislation which health care workers and their managers need to be aware of and comply with
- the importance of adequate documentation in the reporting process
- a process to assist health services in making decisions about appropriate action.

Organisational responsibilities under occupational health and safety and workers' compensation legislation are discussed in Chapter 4.

5.1 LEGAL CONSIDERATIONS

Mandatory reporting and confidentiality are significant legal considerations. As the legal implications vary according to the type of violence and also the state or territory in which it occurs, it is important that health services find out about the legislation that applies in their state or territory and discuss its application in the local setting. As a manager of a health service and as a health care worker, you need to understand when an incident must be reported as opposed to when it may be reported and have procedures in place for decision-making and for reporting.

As a health care worker you are not qualified to give clients legal advice, nor should you be expected to. However, you should be aware that a client may have legal options arising out of their exposure to violence. They may need to be referred to an appropriate legal service for advice on their legal options (eg in regard to criminal injuries, protection orders, family law). In many rural and remote areas legal advice may not be readily or easily available, so it is desirable to develop a list of contacts and services who may be able to provide legal advice even if initially it is only telephone advice. Many legal causes of action are time limited and if a person is not referred to an appropriate legal adviser promptly, their rights may be compromised.

Mandatory reporting

In some cases, you are required by law to report an incident of violence to the appropriate authorities (eg state/territory department for child protection matters and police for criminal matters). Failure to advise the relevant authorities in these situations may have legal implications for health care workers and employers. Each health service should identify the situations in which reporting is legally required.

It is not practicable to specify in this manual the precise situations in which mandatory reporting applies, as each state and territory has its own mandatory reporting requirements as set out in legislation. These differ in relation to how abuse is defined, which professions are required to report and the level of evidence required to make a report. These state and territory laws are also subject to amendment by their own parliaments.

Most mandatory reporting legislation relates to reporting of incidents involving children and young persons. Certain professionals (including health care workers) are required to notify the appropriate state department (eg Department of Community Services in NSW) of situations where a child or young person has been abused or is at risk of abuse (including physical, sexual, emotional, psychological abuse and neglect). The age of a child or young person to which mandatory reporting applies varies between states and territories.

As discussed in Chapter 4, the completing of incident report forms in situations where violence has occurred against workers may be required or assist in meeting obligations under workplace health and safety legislation.

Voluntary reporting

In some states and territories, legislation provides for voluntary reporting. Once you have ascertained whether this situation applies to you as an employer or manager of an organisation, and sought legal advice about the implications of voluntary reporting, you should develop policies that can be actioned in the workplace to assist health care workers make decisions about voluntary reporting.

Confidentiality

Most health care workers are bound by laws and codes of conduct to keep confidential any information about their clients obtained in the course of their work. Health care workers owe their clients a legal and ethical duty not to use or disclose health information without their client's consent. This obligation arises from public interest in maintaining confidentiality.

There are also privacy obligations imposed on health care workers in relation to health information under Commonwealth and some state and territory legislation. Privacy obligations relate to the collection, storage, use and disclosure of personal and health information.

Wherever possible, health care workers should seek client consent before referring clients to the police or reporting violence to authorities, as often this involves providing confidential, personal or health information.

To report or not to report?

In some situations, health care workers will be required to breach confidentiality in order to fulfil the legal obligations of mandatory reporting. This is especially the case where the client has not consented or consent is not sought. In these situations in most states and territories, legal action cannot be taken against a health care worker for a breach of confidentiality or for a breach of privacy. This is because the legislation allows for reporting of suspected cases of child abuse (violence) and this form of disclosure will not amount to a breach of the law or professional ethics or standards.

If you are not specifically required to report under legislation, and you choose to voluntarily report, without your client's consent, you may breach your profession's ethical code of conduct, or legal obligations imposed by privacy legislation. However, much of the state and territory legislation protects people who report voluntarily when they do so in good faith.

As an organisation and employer, you need to be aware of the types of violent episodes that health care workers are obliged to report, and to develop policies about other types of violence that workers might choose to report voluntarily and in good faith. You need to ensure, as best you can, that your health care workers will not be in breach of any laws.

Any breaches arising from incorrect reporting, or failing to report when required to do so, may lead to civil proceedings, disciplinary action or even criminal action.

If a health care worker, employer or organisation is at all unsure about whether reporting is required, whether they can disclose confidential, health or personal information, or whether a breach of confidentiality or privacy may result, you should seek legal advice from a lawyer. A list of contacts for further information is given at the end of this chapter.

Documentation

As a health care worker, you should advise your manager or supervisor about the particular situation, adhere to organisation policy and procedures, and ensure that the process is documented appropriately.

Documentation requirements vary between states and territories and also depend on the type of violent incident. Medical records, incident report forms, case notes, diaries, photographs, examination reports and body maps are documents that may be subpoenaed by a Court or Tribunal for legal proceedings. As such, all documentation should represent an accurate and detailed factual record of the health care worker's observations. Where physical injuries are indicated, photographic evidence is an important part of this documentation. Consent should always be sought before any photos are taken. A camera (such as a Polaroid camera that produces photos instantly) may be needed on site to take photos for file notes. If taken by the health service, photos must be signed and dated by the senior medical practitioner.

5.2 POSSIBLE REACTIONS TO MANDATORY REPORTING

In reporting episodes of violence, you may encounter strong opposition within the community or you may need to report against a relative, friend, fellow worker or employee. The apprehension and detention of the perpetrator may also have an adverse effect on the community. This can have a negative impact on the worker responsible for the report, especially if the community views the mandatory reporting process as socially disruptive rather than as the result of the perpetrator's crime. It is important that the community views the reporting of violent episodes as a consequence of the act, not as something that is being done to perpetrators of violence.

Mandatory reporting of child abuse may be an even more unpopular measure in remote areas than in the suburbs. Such reporting can have a greater impact on all concerned due to factors such as distance from secure accommodation. The protection of the child may mean removal from the community as well as family. Despite these possible responses, it is important to remember that mandatory reporting aims to protect individuals affected by violence. If you do not report an episode of violence that you are legally obliged to report, you are required to accept the consequences, both legal and social.

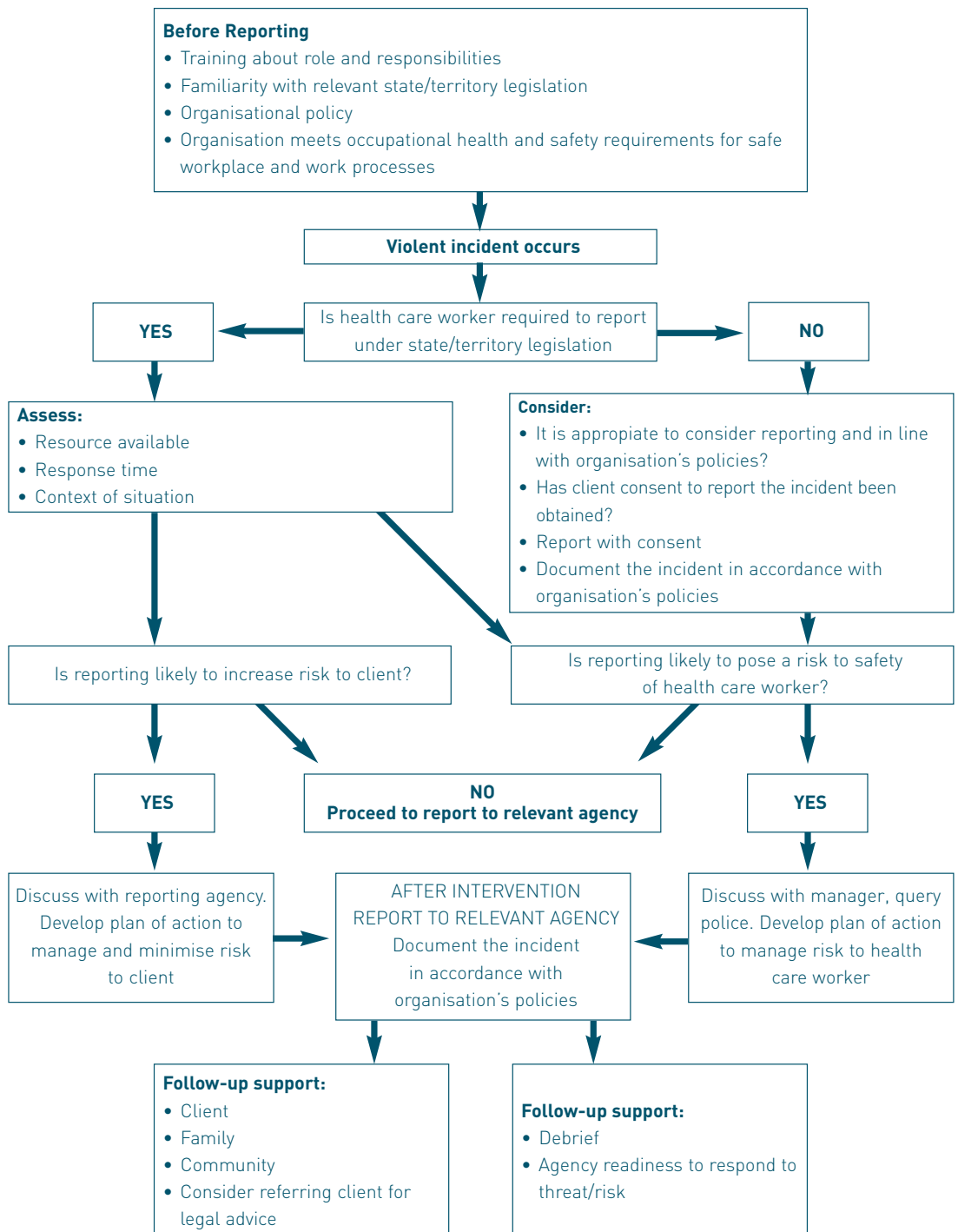
5.3 RISK MANAGEMENT

A risk-management approach may help to identify potential situations before they arise and reduce the possibility of a violent event occurring (see Section 4.3). As it is not possible to eliminate all episodes of violence, it is also important to plan procedures for dealing with episodes of violence when they do occur. As discussed in Chapter 4, it is the responsibility of managers to ensure that these policies and procedures are developed (see Tool 4).

Legal protective options

Using all available means of managing risk may include legal protective options, although these may be of limited value in remote areas. Legal protective orders or injunctions can help clients and assist in the protection of victims of violence, particularly domestic violence. These orders are known by different names in the various states and territories – for example, protection orders, restraining orders and apprehended violence orders. They are also governed by different state, territory and Commonwealth legislation. Therefore health care workers should seek advice from a lawyer about how these orders work in their state or territory. A list of contacts for further information is given at the end of this chapter.

The following flow chart outlines actions you need to take following a violent incident. It is imperative that you meet legal obligations when an episode of violence has occurred. In some situations you may need discussions with agencies first about the best way to proceed in view of the particular circumstances.



5.4 CHECKLIST FOR ACTION

Have you?	Yes	No
A camera on site for immediate photographic documentation of physical injuries?		
Developed tools for the collection and collation of data? (see Tool 3)		
Policies and procedures in place for mandatory reporting? (see Tool 6)		
Contacted state or territory authorities to obtain advice on legal issues associated with mandatory reporting and confidentiality?		
Checked that policies and procedures are developed in line with relevant national and state/territory legislative requirements?		
Checked that relevant national and state/territory legislative requirements are incorporated into procedures where appropriate?		
Considered the consequences of reporting against a client's wishes when you are not legally obliged to?		
Considered referring your client for appropriate legal advice on possible legal action (eg compensation, protective orders, family law)?		
Been appropriately informed about mandatory reporting?		
Been appropriately trained to document your observations in files that may be subpoenaed for use in court or accessed by clients?		
Access to the phone numbers of the nearest firearm licensing branches and/or have you approached them about firearm retrieval strategies?		
Confirmed who coordinates risk-management issues, particularly legal issues and specific medical and forensic information?		
Considered legal protective options to help manage risk?		

FURTHER RESOURCES

Organisation	Website address (URL)*
<i>Information on current state, territory and Commonwealth legislation</i>	
Australian Legal Information Institute	www.austlii.edu.au
SCALE plus	www.scaleplus.law.gov.au
ACT legislation	www.legislation.act.gov.au
NSW legislation	www.legislation.nsw.gov.au
Victorian legislation	www.dms.dpc.vic.gov.au
Queensland legislation	www.legislation.qld.gov.au
South Australia legislation	www.parliament.sa.gov.au
Western Australia legislation	www.slp.wa.gov.au
Northern Territory Legislation	www.nt.gov.au/dcm/legislat
Tasmanian Legislation	www.thelaw.tas.gov.au
<i>Legal information and support</i>	
Aboriginal and Torres Strait Islander legal services	www.powerup.com.au/~atsils/index.html
Australian Institute of Criminology	www.aic.gov.au
Family Court of Australia	www.familycourt.gov.au
Legal Aid ACT	www.legalaid.canberra.net.au
Legal Aid NSW	www.legalaid.nsw.gov.au
Legal Aid NT	www.ntlac.nt.gov.au
Legal Aid Queensland	www.legalaid.qld.gov.au/home/main.htm
Legal Aid SA	www.lsc.sa.gov/contact.htm
Legal Aid Tasmania	www.legalaid.tas.gov.au
Legal Aid Victoria	www.legalaid.vic.gov.au
Legal Aid WA	www.legalaid.wa.gov.au
National Crime Prevention Authority	www.ncavac.gov.au
National Legal Aid Network	www.nla.aust.net.au/html/main.html
National Women's Justice Coalition	www.nwjc.org.au

* See notes about locating websites on page 27.

6 Developing positive outcomes

It is unrealistic to expect that violence will ever disappear completely. But when there are checks and balances in place, violence is less likely to get out of control. In order to achieve this, the overall aims of the community might be to:

- get the issue of violence out into the open, to raise awareness that violence is unacceptable and that it is a problem for everyone in the community, and to promote recognition of the consequences of being violent
- reduce the number of episodes of violence, particularly those that escalate or recur
- work together to develop mechanisms for managing the violence that does occur, to minimise the harm it causes
- promote acceptance in the community that people are held responsible and accountable for the violence they perpetrate
- improve relationships between the health service and the community, and between the health service and other community agencies.

6.1 COMMUNITY RESPONSES

Because every community is different, the problems caused by violence vary. The solutions to these problems cannot be imposed by outside agencies but should be developed as part of a local response by the whole community.

When carrying out community education tasks, being aware of privacy, confidentiality and consent issues is important. Examples of violence where clients can be identified should not be used to educate, as this may have serious legal consequences. In open forums and in presentations, however, clients willing to talk about their own personal situations (as opposed to others' situations) should do so freely.

Protecting those affected by violence

- Working with other community organisations to create a safety net for those affected by violence – helping them to assess risks to their safety, have escape routes in place, develop support networks, know about community services that can assist them (eg counselling, refuge, legal aid) and know their legal rights.
- As a health service, working as a team to identify hazards and manage risks, develop policies and procedures and train staff.
- As a health service, working to provide a safe and supportive environment in which victims of violence feel they can talk about abuse, have their experiences validated and be provided with information and support.

Breaking the cycle of violence

Working with other community organisations to try to:

- raise awareness in communities that reporting violent episodes is a consequence of the act, not something that is being done to perpetrators of violence
- encourage and support or initiate a caring and non-blaming response across the community to address the causes of violence – such as self esteem workshops, support for men at the time that women are taken to shelters as a result of violence, and reintroduction programs to the community for offenders who are leaving prison to return home to their families
- encourage perpetrators to take personal responsibility for their actions and begin their own healing
- encourage men and women to take responsibility for making their families safe
- encourage communities to take responsibility for supporting families to live free from violence.

Educating the community

- Raise community awareness about diversity, to reduce tolerance to violence based on discrimination and make the community safer.
- Tell people about the problem of violence in their community, what the law is, and the consequences of being violent.
- Get people talking about the problems, stop the denial, rebuild values in the community.
- Emphasise that all people in the community, both men and women, have a responsibility to work towards solving their own problems.
- Develop school programs for children which encourage open discussion about identifying and dealing with violence.
- Demonstrate through clinic-led programs the statistics about the types and severity of violence, when it occurs and who is perpetrating violence.
- Keep records of the types of violence experienced by clinic staff so people can make decisions based on local evidence – this can be done through injury prevention programs, clinic statistics and other community resources.

Developing community solutions

Setting up a community violence action group can help to empower the community to find local solutions to issues relating to violence. Depending on the community, these might include women's groups, men's groups, anger management groups, self-esteem workshops, 'building bridges' workshops, family interventions in prisons, and Respect Yourself campaigns (integrated with alcohol programs).

Other community solutions might be to:

- assist individuals who have had enough and want to stop the violence, by encouraging and supporting them to share their stories in safe forums (eg support groups, healing groups)
- develop mediation and conflict resolution advocacy courses and personal development workshops
- encourage and participate in discussions at Neighbourhood Watch workshops, crime prevention programs and other police linked activities
- develop mechanisms for enhancing community safety, such as improving access to information, taking up anti-discrimination policies, and making public places safer (see Tool 6 on making the community safer)
- establish community safe spaces, 'cooling down' places and family violence healing centres
- develop ways to overcome the barriers to reporting episodes of violence, and support mechanisms to help health workers and the community deal with the implications of reporting violence
- develop mechanisms to try to prevent escalation of violence to the point where the health service may be withdrawn from the community
- make best possible use of local capacity, through community organisations and volunteer approaches
- support and encourage community initiatives with as many resources and statistics and as much energy as possible.

What can you do to make it happen?

It's all very well to talk in general terms about what should be done to develop positive outcomes from violence – but what can individuals do to make it happen in their own communities? There are things you can't do on your own and it may take time to feel like you are making an impact on what is an overwhelming issue. There are some specific, practical steps you can take as an individual, as an organisation and as a community, to start the process. Tool 6 has workshop outlines that you can use as a starting point for positive action to make your community safer. You can also find out about what other communities are doing about violence (see Section 6.2 below).

6.2 EXAMPLES OF COMMUNITY RESPONSES

The problem of violence in communities is usually bigger than any one group (such as the health service) can tackle alone. Violence is everyone's problem, not just the problem of those who are directly affected by it. It's important that the whole community works together in partnership to build the capacity of the community to move beyond crisis management and develop long-term solutions to local problems.

Rural and remote communities across Australia are developing solutions to the problem of violence. There are many programs, in varying stages of development, implementation and evaluation. Their experiences may help other communities to develop their own responses.

Following are some examples from across the country, which were gathered through the consultation process. This list does not aim to be comprehensive but to highlight the different types of solutions that are being developed. References or websites that can be accessed for further information on these and other programs are given in the resource section at the end of this chapter.

- Through its *Partnerships Against Domestic Violence*, the Office of the Status of Women has supported a wide range of community-based programs across the country that seek to develop long-term solutions rather than providing crisis care (see Resource section). It has also developed a resource entitled *Is Domestic Violence too Close to Home? A Kit for Rural Women*.
- *Healing Our Families: Apunipima Family Violence Advocacy Project in North Queensland* (Myles & Naden 2002) – this project developed a model to address family violence in Indigenous communities. The model promotes a three-dimensional approach: raising awareness at community level through workshops; developing protocols for improved cooperation, coordination and collaboration between local service providers in communities; and encouraging information sharing and collaboration of regional service providers.
- *Silent Witness programs* – these workshops use art, voice, movement and guided imagery as an adjunct to counselling in the recovery process for women who have experienced domestic violence or sexual assault. The artwork resulting from the workshops becomes part of a Silent Witness Exhibit which can be used to raise awareness about family violence.
- *Reclaim the Night programs* – the philosophy of Reclaim the Night encourages grass roots participation in the organisation of events, drawing together women from diverse backgrounds and experiences to work together in addressing issues of sexual violence against women.
- Family Advocacy Services – these services assist those who are experiencing family violence, in applying for restraining orders, Family Law Court orders and counselling.
- *Butterflies (SA)* – a program for women survivors of family violence in the mid-north region of South Australia, who receive counselling, information and support. Each group continues as a self-sustaining community support group while a new program is established in another area.
- *Yoorana Gunya Family Violence Healing Centre (Forbes, NSW)* – this Indigenous-specific centre provides a range of services including outreach clinics. It also runs projects aiming to reduce levels of domestic violence in the local community by providing access to training programs on prevention and rehabilitation.
- *Changing Gears (SA)* – a program developed in the Adelaide Hills and Southern Fleurieu targeting high schools, with the aim of increasing awareness of the issues and impact of family violence among students and teachers.

- *Solving the Jigsaw: Changing the Culture of Violence (Victoria)* – a program in schools which focuses on the key areas of violence, bullying, depression, anxiety and abuse and which is designed to foster safety, well-being and belonging among young people. The courses are run by trained facilitators and range from short, medium and long term programs at primary and secondary levels. The program also includes linked parenting programs and professional development and information sessions for teachers.
- *Suicide Prevention Program in Yarrabah, North Queensland* – community-driven responses to social issues (including suicide) developed into a Family Life Promotion program for the community. This program has been successful in reducing the number of suicides in the community through: education and counselling; crisis counselling; information and self-awareness programs for survivors of suicide and those at risk; and workshops promoting healthy family life.
- *New England Health Youth Suicide Prevention Program (NSW)* – this service is piloting and evaluating a low cost suicide intervention strategy (the 'Green Card' system). This system aims to address low compliance with treatment by deliberate self harm clients. Clients who are assessed as being at risk of suicide or who have made a previous attempt are offered a Green Card. The Green Card involves access to an on-call Community Mental Health Team member 24 hours a day.
- *Strong Men Groups in the Tiwi Islands* – these workshops encourage men to discuss their problems and issues in a group, with a focus on problem-solving strategies. The concept of men's groups resulted from a community-based strategy.
- *Kempsey Men's Program (NSW)* – this program temporarily removes men from their troubled families, holding sessions around a campfire to discuss problems. These 'group healing sessions' aim to make the men accept responsibility for their actions, seek the approval of their peers and the respected people in the community, and to say sorry.
- *Good Beginnings Prison Parenting Project (Tasmania)* – the program works with inmates, their families and children. It aims to break the cycle of crime and inter-generation violence in families by fostering an awareness of the impact of violence on children. The program aims at providing additional parenting skills, information about growth and development and opportunities to explore new ways of relating with people.
- *Keeping Yourself Safe: An Integrated Workplace Violence Reduction Program (Western Australia)* – this training program was developed on-site to provide workers considered most 'at risk' with skills to reduce the potential for occupational violence and to reduce the risk of harm to self and others in the event of actual violence. The training is designed to enable staff to learn and practise interpersonal skills aimed towards conflict management to reduce aggressive behaviour and to respond appropriately to episodes of actual aggression.
- *Employee Assistance Service NT Inc* – this is a non-government, community-based, territory-wide organisation that provides counselling, training and consulting to the NT workforce. Counselling aims to assist staff in working through personal problems which may be having an impact in the workplace. Training is offered in areas such as communication skills, assertiveness, conflict resolution and critical incident stress management.

FURTHER RESOURCES

Publications

Title	Description	Reference
<i>Domestic and family violence</i>		
<i>Domestic Violence: Special Needs Of Aboriginal Women Living in Aboriginal Communities</i>		Allbrook Cattalini Research (1992)
<i>Working with Adolescents to Prevent Domestic Violence: Indigenous Rural Model</i>		Blagg (1999)
<i>Crisis Intervention in Aboriginal Family Violence</i>		Blagg (2000)
<i>Literature Review on Models of Coordination and Integration of Service Delivery</i>		DVCWA (2000)
<i>Working with Adolescents to Prevent Domestic Violence: Rural Town Model</i>		Indermaur et al (1998)
<i>Is Domestic Violence too Close to Home? A Kit for Rural Women</i>		Lodden-Mallee Women's Health (1997)
<i>Healing our Families: The Story of Apunipima's Family Violence Advocacy Project (Part 4)</i>		Myles & Naden (2002)
<i>Working Together Against Violence: The Report of the First Three Years of the Commonwealth Initiative Partnerships Against Domestic Violence</i>		PADV (2001)
<i>The Next Step: Queensland Government Response to the Aboriginal and Torres Strait Islander Women's Task Force on Violence Report</i>	Evaluation of Stage 1 of an initiative to combat domestic violence against women trialed in eight Queensland sites involving screening of clients presenting to health services	Queensland Department of Aboriginal and Torres Strait Islander Policy and Development (2000)

Publications

Title	Description	Reference
<i>Domestic and family violence cont.</i>		
<i>Initiative to Combat the Health Impact of Domestic Violence Against Women Stage 1: Evaluation Report</i>	Evaluation of Stage 2 of an initiative to combat the impact of domestic violence against women implemented in 17 Queensland sites involving screening of clients presenting to health services	Queensland Health (2000a)
<i>Initiative to Combat the Health Impact of Domestic Violence Against Women Stage 2: Report</i>	Sets out high level plan for reducing injuries resulting from assaults and alcohol, including community based projects in rural and remote areas	Queensland Health (2000b)
<i>Learning Communities, Regional Sustainability and the Learning Society: An International Symposium</i>	Reports on range of strategies to address needs of young people in rural communities, and highlights importance of involvement by young people and the local community, collaboration across agencies and diverse approaches	Stokes & Wyn (1998)
<i>Police Culture and the Handling of Domestic Violence: an Urban/Rural Comparison</i>		Knowles (1996)
<i>Changing Attitudes: Rural Responses to Women and Domestic Violence</i>		Lovell (1996)
<i>Successful Domestic Violence Prevention in Rural Communities</i>		McMahon et al (1999)
<i>Atunypa Wiru Minyma Uwankaraku: Good Protection For All Women, NT. Violence Prevention in Practice</i>		Mugford & Nelson (Compilers) (1996)
Rural Domestic Violence Project, TAS. Violence Prevention in Practice		Mugford & Nelson (Compilers) (1996)
'Walk away, cool down campaign': a domestic violence reduction campaign	Reports on a domestic violence reduction campaign carried out in Indigenous communities in far north Queensland	Walk Away Cool Down (2001) www.dvcairns.org

Publications

Title	Description	Reference
<i>Violence against women</i>		
<i>Joint Conference of the AASW, IFSW, APASWE and AASWWE</i>	Reports on implementing in rural areas NSW Government strategy to reduce violence against women, including partnership approach and focus on prevention	Hastings & MacLean (1999)
Women 2001	Provides information on services available to victims of domestic violence across the country and information for family and friends on how to support people who may be experiencing domestic violence	OSW (2001)
<i>Sexual assault</i>		
<i>Crimes of Violence: Australian Responses to Rape and Child Sexual Assault</i>	Sets out considerations to be taken into account in setting up sexual assault services in rural areas	Breckenridge & Carmody (eds) (1992)
<i>Australian Institute of Criminology Conference</i>	Report on programs for male adolescent sexual offenders in Gippsland and Mildura in rural Victoria	Makepeace et al (2001)
<i>Child abuse</i>		
<i>Looking After Children Grandmothers' Way</i>	Reports on ideas about child protection in Indigenous communities in central Australia	Harrison (1991)
<i>Preventing Child Abuse and Neglect</i>	Reports on national audit of child abuse and neglect prevention programs	Tomison & Poole (2000)
<i>Aboriginal and Torres Strait Islander peoples</i>		
Health, Rights and Discrimination: Some of the Success Stories for Aboriginal Peoples and Torres Strait Islanders	Discusses the importance of self-determination for Indigenous communities in addressing community development needs	Burney (2001)
Aboriginal Justice Issues	Reports on issues around developing a community based approach to crime prevention in Aurukun, Queensland	McKillop (1992)

Publications

Title	Description	Reference
Alcohol-related violence		
<i>The Health Outcomes Plan: Injury Prevention and Control</i>	Sets out background information on violence against women and canvasses possible strategies to address the problem	Queensland Health (2000)
Journal articles		
Models of excellence in Indigenous community health: Part four – Tennant Creek		Ellis (1996)
Getting in before the heart starter: controlling alcohol, violence and environmental hazards		Flick (1996)
Men exploring new directions		Franks (2000)
Women's work against violence: community responses in a rural setting		La Nauze & Rutherford (1997)
Remaking the connections: an aboriginal response to domestic violence		Smith & Williams 1992

Note: Full publication details are given in the Bibliography (see page 83).

Websites

Organisation	Website address (URL)*
Australian Institute of Criminology Australian Violence Prevention Awards	www.aic.gov.au/avpa/2001.html
National Crime Prevention Authority	www.ncavac.gov.au/ncpa
Office of Status of Women	www.padv.dpmc.gov.au
Domestic violence kit for rural women	www.osw.dpmc.gov.au/rural/violence.htm

* See notes about locating websites on page 27.

Membership and terms of reference of the Working Party

Membership

Ms Kerry Arabena	Health Advisory Committee representative, Chairperson
Dr Rosemary Aldrich	Health Advisory Committee representative and public health physician, Deputy chairperson
Ms Carmel Brophy	Representative from Health Consumers of Rural Remote Australia
Ms Glenda Brown	Indigenous health worker
Ms Viki Brummell	Rural health care worker
Mr Neil Harris	National Occupational Health and Safety Commission
Dr Peter Joseph	Health Advisory Committee representative and general practitioner
Ms Kerrie Kelly	Psychologist and Coordinator, CRANA Personal Support Network (Bush Crisis Line)
Ms Daphne Naden	Indigenous health worker
Mr Frank Spry	Indigenous health worker
Mr Robert Williams	Psychologist, Royal Flying Doctor Service of Australia (Queensland Section)

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Ms Kristine Fisher	Health Advisory Section, NHMRC

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Terms of reference

- Conduct a literature review on episodes of violence in rural/remote communities including the impact of health outcomes for clients and health service delivery.
- Develop a manual for rural/remote health care workers, managers and employers.
- Conduct wide consultation with relevant stakeholders.
- Develop an implementation, dissemination and evaluation strategy for the manual.
- Focus test the manual to ensure its useability.
- Recommend future research needs to the NHMRC.
- Present a manual to the Health Advisory Committee and Council for issuing.

Process report

In August 2000, the Health Advisory Committee, a principal committee of the NHMRC, highlighted the effects of episodes of violence in rural and remote communities as a public health issue of increasing importance. The Health Advisory Committee established an expert, multidisciplinary working party to develop the manual *'When it's right in front of you: assisting health care workers to manage the effects of violence in rural and remote Australia'*.

An analysis of the literature on the epidemiology of violence and resources relevant to the management of violence by health workers in rural and remote communities of Australia was undertaken following a request for tender for literature reviewer services.

Consultation for the development of the manual has included professional organisations and individual health care workers in rural and remote Australia, including an invitation for working party representation on a voluntary basis; a call for public submissions on the draft document; and an invitation to health practitioners to participate in a workshop. A project proposal was presented at the 6th National Rural Health Conference in March 2001 at which potential membership of the Working Party was canvassed. In addition a project outline was presented at the Public Health Association of New Zealand annual conference in July 2001 and at the Public Health Association Conference of Australia annual conference in September 2001.

Mindful of the vast amount of relevant expertise to be drawn upon, the Working Party Chair met with representatives of the Department of Family and Community Services, the Attorney-General's Department, the Office of the Status of Women of the Department of Prime Minister and Cabinet, the Office of Aboriginal and Torres Strait Islander Health of the Department of Health and Ageing, the Research Agenda Working Group and the ACT Chief Minister's Department.

Public consultation on the draft manual took place during February and March 2002 and involved a call for submissions on the draft manual publicised in the *Government Notices Gazette* and *The Weekend Australian*, and invitations forwarded to all professional colleges and known interested parties.

Submissions were received from the following individuals/ organisations:

Roberto A Rojas	National Office Family Planning Australia
Chris Mitchell	Queensland Rural Medical Support Agency
Joy Burch	Northern Territory Remote Health Workforce Agency
Dr David Plummer	Department of Public and Community Health University of New England NSW
Melanie van Haaren	National Secretariat Council of Remote Area Nurses of Australia Inc.
Kerren Clark	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Alan Caple	Work Health and Electrical Safety Department of Employment, Education and Training Northern Territory Government

Christine O'Farrell	Country Services Department of Health Government of Western Australia
Professor Beverley Raphael	Centre for Mental Health NSW Health Department New South Wales Government
Jill Iliffe	Australian Nursing Federation
Janelle Stirling	Indigenous Health Research Program Queensland Institute of Medical Research
Dr Jonathon Phillips	Committee of Presidents of Medical Colleges
Robert Seljak	Division of Workplace Health and Safety Department of Industrial Relations Queensland Government
Professor Duncan Chappell & Dr Claire Mayhew	Taskforce on Prevention and Management of Violence in the Health Workplace, Mental Health Review Tribunal NSW Government
Howard Cleaver	Community Health Services Primary & Extended Care Services Mid North Coast Area Health Service NSW
Margaret Norington	Substance Abuse and Men's Health Section/ Social Health Section, Health and Community Strategies Branch Office of Aboriginal and Torres Strait Islander Health Commonwealth Government
Phillipa McLean	Women's Health Victoria
Kerry Sculthorpe	Strategic Development National Policy Office Aboriginal and Torres Strait Islander Commission Commonwealth Government
Matthew Hunt	Health Consumers' Council of Western Australia
Professor Louis I Landau	Faculty of Medicine and Dentistry University of Western Australia
Sandra Moait & Trish Butrej	NSW Nurses' Association
Dr Steve Buckland	Southern Zone Management Unit Queensland Health Queensland Government
David Lindsay	School of Nursing Sciences James Cook University QLD
Jeff Smith	Industry Strategies Unit Workcover NSW New South Wales Government

Rosemary Bryant	Royal College of Nursing of Australia
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The Working Party met on 3 April 2002 to discuss these submissions and their inclusion in the manual.

A workshop involving practitioners with experience in rural health care was conducted in Sydney on 21 May 2002. The workshop was facilitated by Colmar Brunton Social Research and involved the following participants:

Mr Tom Brideson	Office for Aboriginal & Torres Strait Islander Health, Commonwealth Department of Health and Ageing
Dr Andrew Christopherson	Royal Flying Doctors Service of Australia (Queensland Section)
Ms Gillian Davies	NSW Nurses Association
Ms Anne Dunne	Woorabinda Multipurpose Health Service QLD
Ms Bernadette Edwards	Bush Crisis QLD
Ms Victoria Gilmore	Aust Nursing Federation
Ms Siobhan Harpur	Aged, Rural and Community Health, Department of Health & Human Services TAS
Mr Zane Hugues	Indigenous health worker
Mr John Langrell	Council of Remote Area Nurses of Australia
Ms Susan Rath	Cairns Base Hospital QLD
Ms Jenny Reath	Royal Australian College of General Practitioners (NSW)
Ms Susan Stratigos	Rural Doctors Association ACT
Dr Dave Templeton	Australian College of Sexual Physicians
Ms Helen Webb	Health Department of WA

The following members of the NHMRC Rural and Remote Health Care Workers Working Party, its secretary and two technical writers also attended the workshop:

Ms Kerry Arabena	Ms Daphne Naden
Ms Carmel Brophy	Mr Robert Williams
Ms Viki Brummell	Mr Nicholas Duell
Mr Neil Harris	Ms Elizabeth Hall
Dr Peter Joseph	Ms Jenny Zangger
Ms Kerrie Kelly	

The Working Party met on 22 May 2002 in order to discuss the outcomes of the workshop and to consider the inclusion of comments received in the draft manual .

Prior to approval by the NHMRC, the manual was subjected to an independent review against the NHMRC key criteria for assessing information reports, and the legal sections of the manual were then subjected to an independent legal analysis.

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Tool 1 How you can recognise the different types of violence

What is in this tool?

- *Section 1* describes some common types of violence that you may encounter (either through clients or colleagues, or through violence you experience yourself), their effects and some general points to guide your response.*
- *Section 2* outlines some physical, emotional and psychological indicators of violence, including those that may suggest homicidal risk or risk of self-harm.
- *Section 3* provides a set of questions to help you to encourage clients or colleagues to discuss their experiences of violence.
- *Section 4* outlines what you need to consider once you have established that a client or colleague has been affected by violence.
- *Section 5* includes an example of how this information can be put into practice. The action checklist in Section 2.6 of Part A may also assist you in being prepared to respond to people affected by any type of violence.

Why should you read and use this tool?

The information provided in this tool will assist you to respond to different types of violence through:

- raising your awareness of the different types of violence
- helping you to recognise indicators of violence or risk of homicide or self-harm in adults
- guiding you in encouraging clients to discuss their experience of violence
- helping you to be prepared to meet the needs of people affected by violence and to fulfil your duty of care and legal obligations.

Having a greater understanding of the different types of violence and considerations for responding will also help the management of your organisation to ensure that all relevant types of violence are covered in local policies and in the approach to risk management.

Where can you get more information?

If you would like more information about any type of violence, refer to the resources and references listed in Part A of this manual (in particular those in Chapter 5 which provide details on who to contact for information about legal obligations in your state or territory).

This tool is designed to complement the other tools in the toolkit to guide you in putting the theory outlined in Part A into practice.

SECTION 1 – WHAT ARE THE DIFFERENT TYPES OF VIOLENCE?

There are many different types of violence, and anyone in the community can be affected. The impact of violence varies widely – for example, there will be different consequences for victims of a one-off episode of violence (such as a pub brawl) than for victims of sustained sexual or domestic violence. Your response will also depend on the type of violence that has affected your client (eg you will need to report cases of child abuse to the relevant authorities or refer cases of self-harm to mental health services).

* The descriptions in this tool are not intended as definitions of the different types of violence and are not necessarily consistent with definitions used in legislation.

However, there are a number of considerations that are common to all types of violence. Health care workers' immediate responses range from simple first aid or medical treatment to rapid referral to the police or emergency services (as available). Injuries and other harm should be documented in the client's case notes, bearing in mind that the documentation may be subpoenaed as evidence (see Tool 3). In cases of violence against yourself or a colleague, an incident report form should also be completed (see Tool 3). There may also be reporting requirements under state or territory legislation (see the *Further resources* section of Chapter 5).

Remember that your ability to assist your clients may be affected if you have been a victim of violence yourself.

Physical assault

- Physical assault is where one person inflicts force or injury upon another (excluding assault of a sexual nature). Physical assault that is not family and domestic violence generally occurs between men, and is often associated with excess alcohol. Assaults can range from fist fights to use of weapons and even homicide. Physical assault may also occur as part of other criminal activity (eg during a robbery).
- The effects of assault may range from minimal harm or minor injuries through to death. There are also likely to be psychological effects, particularly if the assault is repeated (eg ongoing conflict between two families).

Self-harm and suicide

- Self-harm is where a person intentionally injures themselves. It is likely that self-harm arises from problems in the person's life and they are likely to need counselling or referral to mental health services. There may also be a need to call on the community to support the individual. Attempted self-harm is often a cry for help and can also be a powerful manipulative device.
- The effects of self-harm range from minor self-inflicted injuries to self-mutilation, attempted suicide and completed suicide.

Family and domestic violence

- Family and domestic violence is where one person attempts to control others within a family or domestic relationship. This may include members of the extended family (grandparents, aunts, cousins etc). It can take the form of physical, psychological, social, sexual or economic abuse. This form of violence is most commonly perpetrated by men against women (including pregnant women) and/or children.
- Women in rural and remote areas may have difficulty in protecting themselves from violence in the home. Many are isolated and may not have ready access to a car or phone. Access to firearms is widespread. Police and other community support services are often limited, and there are few safe places to go. In many communities, the health clinic is somewhere to escape to as well as a place to seek treatment.

Child abuse

- Child abuse is mistreatment or neglect of a child that results in harm or injury. This includes physical abuse (injuring a child), emotional abuse (eg verbal attacks, threats or humiliation), sexual abuse (any sexual contact with a child, using a child for sexual films, pictures or

prostitution, obscene language, or exposure not involving contact) and neglect (knowingly failing to provide for a child's emotional or physical needs, and failing to offer guidance and supervision).

- Child abuse is a serious crime and in most states and territories known or suspected cases must be reported to the relevant authority in your area. There are legal consequences if reporting is not carried out. Skilled counselling is needed to help children recover from abuse, as it can have lasting effects into adult life.

Sexual abuse

- Sexual abuse ranges from sexual harassment (unwelcome physical, verbal or non-verbal conduct of a sexual nature that offends, humiliates or intimidates the victim), to various forms of sexual assault (eg rape). A history of sexual abuse can leave survivors feeling that they have no control over their lives and the way in which people treat them.
- It is helpful to be aware that some women who have experienced sexual abuse may have an increased sensitivity to a number of medical procedures that appear straightforward and uncomplicated (eg Pap smears, ultrasounds, childbirth, vaginal or anal examinations, breast checks, dental work and invasive techniques).

Harassment and bullying

- Violence isn't always physical. Harassment, bullying, stalking or threats of violence, either at home or at work, can be frightening and seriously affect a person's quality of life. Common types of harassment and bullying include verbal abuse, unwanted touching or pinching, homophobic harassment in schools or workplaces and use of sexual, sexist or homophobic language or behaviours to exert power.
- These forms of violence need to be acknowledged and dealt with in the same way as violence that causes physical harm.

Discrimination

- Discrimination is unpleasant or less favourable treatment of a person or group of people because of their race, colour, descent, national or ethnic origin, gender or sexuality. Homophobic violence is an expression of discrimination against gay men and lesbians, which plays an important role in bullying and harassment in peer groups in both childhood and adulthood.
- Discrimination of any type may show itself as unpleasant oral, written, depicted or physical behaviour directed at a person or group. It frequently results in mental, emotional or physical discomfort, embarrassment or harm. No individual or group is immune to social discrimination. Discrimination is against the law and should not be accepted in any workplace or social situation.

SECTION 2 – WHAT ARE SOME POSSIBLE INDICATORS OF VIOLENCE?*

It is not always obvious whether injury or other harm has resulted from violence or from other causes. In some cases people will try to conceal the cause of harm, often to protect the perpetrator out of fear or loyalty or to avoid the possible repercussions. The effects of psychological and emotional abuse may be more difficult to recognise. The table below lists some possible indicators to guide you in identifying the effects of violence. Indicators of sexual abuse will differ depending on the person's age and experience.

* This section is adapted from Eastern Perth Public & Community Health Unit WA (2001) *Responding to Family Violence, a Guide for Health Care Workers in Western Australia*. Eastern Perth Public and Community Health Unit, Perth. www.health.wa.gov.au/publication.respondingtoFDV.pdf

Physical

- Head, neck and facial injuries
- Inadequately explained physical injuries (eg fractures)
- Multiple and bilateral soft tissue injuries especially contusions and abrasions
- Injuries on parts of the body hidden from view (eg injuries to breast, abdomen or genitals)
- Bruises of various ages
- Ongoing complaints of poor health (eg chronic pain syndrome)
- Previous history of violence
- Back pain
- Neck stiffness
- Ulcers
- Headaches
- Dizziness
- Numbness
- Palpitations
- Miscarriage and other pregnancy complications
- History of gynaecological problems
- Substantial delay between time of injury and presentation for treatment

Psychological and emotional

- Recurring abuse will lead to other illness and emotional problems that on the surface may not appear related to violence
- Cases of child abuse and neglect may be linked to family and domestic violence
- Repeated visits to hospital emergency departments for stress-related symptoms. These may have been previously treated with pain killers/antidepressants
- Unexplained bodily complaints
- Gastrointestinal disturbances
- Post-traumatic stress disorder
- Emotional distress (eg anxiety, indecisiveness, confusion, hostility)
- Sleep disturbances
- Depression
- Substance abuse (including prescribed drugs)
- Self-harm behaviours, suicide attempts
- Withdrawal from touch
- Client is evasive or embarrassed about injuries
- Partner speaks for client and/or insists on remaining with client

Homicidal risk

- Access to guns or weapons
- Perpetrator has killed animals/pets with intention of frightening family member(s)
- Perpetrator has threatened to kill the victim
- Use of drugs or alcohol by the perpetrator
- The perpetrator is known to be violent

Risk of self-harm

- Depression
- Alcohol or substance abuse
- Access to guns or weapons
- Social withdrawal
- Signs of psychological distress[#]
- Precipitating events (eg interpersonal loss or conflict, economic or legal problems)
- Person has threatened to kill themselves

[#] A number of scales for assessing psychological distress have been developed. Such tests can be useful but they should not be used as a stand-alone assessment of psychological distress. It is also important to ensure that there is some form of follow-up after the results of the test have been assessed (eg referral to mental health services; contact with Bush Crisis Line).

SECTION 3 – HOW CAN YOU LEARN MORE FROM YOUR CLIENTS?*

When your assessment indicates that a client may have been a victim of violence, it may be appropriate to question them further about their injuries. The following questions are examples of ways to encourage people to discuss episodes of violence. Direct questions may be more productive in drawing out information. However, being sensitive to the person's age, culture, experiences and context is the most important thing to consider.

- 'Do you know the person who did this to you?'
- 'Has this person threatened or harmed you before?'
- 'This does not look like a fall. Did someone do this to you?'
- 'Has this happened before?'
- 'When did it first happen?'
- 'How badly have you been hurt in the past?'
- 'What have you done in the past to protect yourself?'
- 'Where have you been to get help?'
- 'Does your partner threaten you?'
- 'Are you scared at home?'
- 'Are the children in danger?'
- 'Do you want to stop this happening?'

Sometimes clients may react angrily to their situation and to your questioning. Tool 3 outlines some ways to help you deal with anger and aggression.

SECTION 4 – WHAT DO YOU DO NEXT?

- Your first concern should be to provide whatever medical attention is required to anyone who has been harmed.
- When you have attended to the person's needs, ensure that you have accurately documented the injuries and the client's psychological state, being aware that documentation may be subpoenaed as evidence (see Tool 3).
- If appropriate, refer the person to available support services (eg social worker, counsellor). Referral networks will help you to get the right help as quickly as possible and reduce the feeling that you have to manage on your own.
- Make sure that you have reported the incident to the appropriate authority if you are required to do so under legislation in your state or territory. Obtain consent from the client before reporting whenever possible. If you or a colleague have been affected by violence you will also need to complete an incident report form (see Tool 3).
- As with any health care, treatment of injuries or other harm resulting from violence requires follow-up. For clients, this is likely to include continuing care and referral to other relevant agencies. If it is you or a colleague who has been harmed, your organisation's procedure for recovery and review should be followed.

* This section is adapted from Eastern Perth Public & Community Health Unit WA (2001) *Responding to Family Violence, a Guide for Health Care Workers in Western Australia*. Eastern Perth Public and Community Health Unit, Perth. www.health.wa.gov.au/publication.respondingtoFDV.pdf

What can be expected of management

- Support services to facilitate recovery following exposure to violent events can be provided at a number of levels. These include the provision of information, help lines (such as the Bush Crisis Line), access to employee assistance programs and supportive management of work-related traumatic events, including on-site interventions for individuals, teams and communities if this is required.
- Lessons learned through the incident can contribute to planning to protect clients and workers in the future (eg it may be better to see a client known for aggression in the company of a support person who is able to calm them down).
- If violent incidents in the health service occur frequently, it may be necessary to make changes to the structure itself (eg an interview room should have two exits) and to provide workers with ways to get assistance (eg duress alarms). Tool 6 includes information on accessing clients safely.

SECTION 5 – PUTTING IT INTO PRACTICE

A young man repeatedly attends the health service with minor injuries. He is not very communicative and says that the scratches and bruises are from playing sport. As the nurse is attending to the wounds, she comments that they do not look like they resulted from a basketball game. The man's manner is guarded and he does not want to discuss the cause of the injuries. He says that things are fine at home although he is not sleeping well and has headaches.

The nurse reviews the man's case notes and the following week when he returns to the health service with bruising and abrasions on his forehead and severe bruising on his upper left arm, asks whether someone has done this to him on purpose. The man admits that there have been repeated fights between himself and his father and older brothers as he is supportive of his mother getting a job. He wants to move away but is afraid for his mother's safety and for his own.

An x-ray of the man's arm is organised. The nurse advises him to attend counselling, giving him information about mental health services in the region (he may need a ride out with the Flying Doctor Service to attend). She asks his permission to disclose information about his case to the mental health service. The man is also given information about a safe house in a nearby community where he and his mother can seek refuge.

After obtaining his consent, the nurse photographs the young man's face and arm. She checks that she has taken a proper record of his injuries and considers whether she is required to report the incident to the relevant child protection authority or health department in her state or territory. She also reviews the case notes of the man's family, three of whom attend the health service. She notes that there are no children endangered through living with the family.

She asks him if he is able to make the phone calls to the safe house and the counsellor in safety, or in a place that he cannot be disturbed. She offers to make the phone calls on his behalf and reviews a contact list of people who can help. She makes the first phone calls with him, and then hands the phone over to leave him to speak with the counsellor and the safe house. She documents the appointments he has made with them and assures him that he can contact her agency for ongoing medical attention for himself and others who are at risk. She checks he is okay before he leaves the room and assures him that everything is confidential.

Tool 2 How you can manage anger and aggression

What is in this tool?

- *Section 1* suggests some strategies for responding to an angry person.
- *Section 2* outlines some tips to help you maintain your personal safety when confronted with an aggressive individual.
- *Section 3* provides guidance on dealing with your own anger.
- *Section 4* includes an example that shows how this information can be put into practice.

Why should you read and use this tool?

- The difficulties and dangers of rural and remote health practice can combine to produce high levels of stress. The combination of high levels of violence in the community and high levels of stress within the workplace mean that you are more likely to find yourself faced with an angry or aggressive individual or to feel frustrated or angry yourself.
- Not all violent situations can be controlled, but this tool will help you to be better prepared to deal with conflict safely. It will also help you to use your own anger constructively rather than destructively.
- Having a greater understanding of ways to deal with anger and aggression will also help the management of your organisation to ensure that all safety issues are covered in the health service's policies on occupational health and safety and violence and in the approach to risk management.

Where can you get more information?

If you'd like more information, refer to the resources and references listed in Part A of this manual (in particular those given in Chapter 3).

If you feel that you are not coping with your own anger or other emotions such as anxiety and support is not available locally, call the Bush Crisis Line on 1800 805 391.

This tool is designed to complement the other tools in the toolkit to guide you in putting the theory outlined in Part A into practice.

Sources

This tool has been developed by the working party based on their expertise and the following sources:

- Kelly K (2000) *Avoiding Burn-Out in Remote Areas. Surviving the Day to Day Hassles: A Guide For Remote Health Practitioners*. Council of Remote Area Nurses of Australia Inc.
- Treatment Protocol Project (1997) *Management of Mental Disorders*. (2nd edition). World Health Organization Collaborating Centre for Mental Health and Substance Abuse, Sydney.

SECTION 1 – HOW DO YOU MANAGE AN ANGRY PERSON?

Sometimes clients may be angry about what has happened to them or about how their situation has been dealt with by the health service. As a general principle it is important to try to de-escalate conflict and bring emotions to a level where constructive dialogue can take place. Reacting to the anger by becoming aggressive or withdrawing can make things worse.

Following are some suggested strategies for responding to an angry person.

- Remain calm and respectful.
- Listen and say nothing for the moment.
- Show empathy.
- Remove the person to a private part of the health service.
- Apologise without accepting blame.
- Ask questions if necessary in a polite, even-handed manner.
- Take a neutral stance on the cause of the person's anger.
- Do not offer excuses or argue.
- Suggest a strategy to deal with the person's concerns, including a timeframe.

Sometimes anger arising from a client's past may be carried into the current situation. Such anger may be sudden and inexplicable. Developing an understanding of the political and historical environment in which you work may help you to avoid such incidents and increase your safety and that of your clients.

SECTION 2 – WHAT DO YOU DO IF SOMEONE BECOMES AGGRESSIVE?

The most important factor when dealing with an aggressive individual is to maintain personal safety at all times. The tips given below offer commonsense approaches with safety being a primary concern. While the tips will provide you with some guidance, there is no single or correct way to react and you will need to use your expertise to assess the situation and choose the most appropriate plan of action.

It is important to be aware of cultural considerations, particularly concerning non-verbal behaviour – some behaviours may be appropriate in one culture but not in another. The context and the number of people involved are also important and may affect the way you respond.

If you are anxious or fearful about seeing a client, talk to your manager or a colleague about alternatives. It may be that a colleague can be present during the consultation or attend to the client themselves. You may feel more confident about managing anger or aggression if you talk to a colleague who is more experienced in dealing with violence or consult additional resources on coping with aggressive individuals.

Never turn your back on the individual

- Observe continuously but avoid direct eye contact. Don't walk ahead of the individual and stand at least an arm's length away.

Let the individual talk

- Avoid interrupting but if you have to do it quietly and calmly.

Ensure a safe escape route

- Try not to corner the person. Consider how you might escape and, if possible, ensure that both the aggressive individual and yourself have equal access to a safe exit.

Ensure a safe environment

- Make the environment as safe as possible. You could do this by installing a discreet buzzer or intercom, having other staff members clearly visible or at least frequently passing the room, forewarning others if a potentially aggressive person is visiting, minimising potential weapons etc.

Minimise risks for home visits

- Only visit clients at home if you know the person and their family well. If there is a risk of violence always have another worker with you and inform others where you are going and the time you are expected back.

Don't be a hero

- Get help from wherever you can. Think **SAFETY FIRST**.

Weapons

- **NEVER try to disarm an individual who has a weapon.** If the individual claims to have a weapon, take his or her word for it and **GET OUT**. If you suspect that the individual has a weapon, **GET OUT**. Call security or the police immediately.
- If you work in an area where it is likely that it will take time for backup to arrive, have a fallback plan (such as locking yourself in a room within the health service).

If you cannot escape

- Stay calm.
- Try to get help if possible.
- Do not wrestle with the aggressor.
- Adopt a passive and non-threatening body posture (eg hands by side with empty palms facing forward, turn side on to the aggressor (at 45 degree angle), minimise eye contact).
- Be observant and try to maintain a clear understanding of what is happening.
- Be prepared for rapid self-protection if necessary.
- Obey the individual's instructions and try not to upset him or her.
- Use surrounding objects and furniture as shields if aggression occurs.
- Escape if a safe opportunity arises (it is useful to plan escape routes before the need arises).

Remove 'dangerous' objects

- Scissors, knives or any unnecessary objects that can be picked up and thrown (eg glass ashtrays) should not be kept in the interview room.
- Try not to wear clothing or accessories which could be used as a potential weapon (eg necktie, necklaces, cigarette lighters).

SECTION 3 – HOW DO YOU MANAGE YOUR OWN ANGER?

Anger is a natural, healthy emotion that can help you to recognise when you or your well-being are at risk. However, in small teams and community settings, uncontrolled anger can destroy relationships and erode the goodwill that you have built up. Reacting angrily often only makes the situation worse.

Before you get angry:

- Identify those events and behaviours that can trigger your anger.
- Avoid setting yourself up to get angry.

- If your anger indicates a threat to your well-being, plan to address it in a cool-headed way, rather than just venting your emotions in the heat of the moment.
- Develop a few coping strategies to defuse your angry reactions before you lash out at others (eg counting to 10, taking a few deep breaths, leaving the situation, going off alone to cool down, engaging in physical activity, using relaxation exercises or working out a resolution within yourself).

When you feel angry:

- Acknowledge but do not indulge the emotion.
- Use the coping strategies you have developed to cool the anger.
- Think about the situation – is there anything you need to do?, is there a threat to your well-being?, or was your anger the result of overall stress?
- Try to achieve a calm state of mind before working out a plan to deal with a problem.
- Be careful when driving a motor vehicle as it is easy to use a vehicle as a weapon and express anger in your driving.
- Do not allow your anger to build on itself – challenge any negative thoughts that may be fuelling your anger or distract yourself to help prevent a negative train of thought from escalating or maintaining your anger (eg by reading or watching TV).
- Plan to deal with the problem constructively – begin with the desired outcome in mind and use assertive communication skills to achieve what you want.

SECTION 4 – PUTTING IT INTO PRACTICE

A client comes into the clinic and demands to see a nurse. The wardman reports to the nurse that the client seems very agitated and is pacing up and down the waiting area. He reports that the client has blood on his hand and at one point thumped his fist on a table in the waiting room.

Judging that the client is potentially violent the nurse asks the wardman to remain in sight during the interview with the client.

She asks the client to come into a room, which is used for interviewing, and has been cleared of any potential weapons or missiles.

The client launches into a torrent of abuse about how the clinic won't give him a letter and that he doesn't have any money. The client is extremely angry and much of the anger is directed towards how useless the medical profession is.

The nurse makes sure that she stands out of reach of the client if he were to strike out with his hands or feet. She remains calm (although she doesn't feel calm) and is respectful to the client (although she doesn't feel like being respectful). She acknowledges that she feels angry but does not show this. She states that she can see that the client is very angry and that if he can explain what needs to be done she may be able to help. As the client begins to calm down he explains that a letter is required from the clinic to enable some funds to be released. He had been so angry about not having any money that he had put his fist through a wall.

The client's anger is de-escalated after a calm and empathetic response from the nurse. A strategy to address the client's problem is discussed, the letter is provided and his hand treated. The nurse carefully documents the nature of the injury. The nurse considers whether she or the wardman needs to complete an incident report form and discusses this with her manager.

Tool 3 How you can document the effects of violence

What is in this tool?

- *Section 1* describes the different kinds of documentation and when they are used.
- *Section 2* provides forms for documenting injuries and gives an example of how they are used.
- *Section 3* provides a form for documenting psychological effects of violence.
- *Section 4* provides an incident report form for documenting occupational violence and gives an example of how the form is used.
- *Section 5* provides a checklist for obtaining photographic evidence.

Please note that this tool contains diagrams of human genitals

Also note that the names of people, dates of birth, and incidents referred to in sample notes in this tool are entirely fictional and are included for the purposes of showing how to complete case notes; any resemblance to any real people and incidents is entirely coincidental and unintended.

Why should you read and use this tool?

- As a health care worker, you need to keep clear, objective case notes, which include proper documentation of harm resulting from violence. Documentation requirements vary between states and territories and also depend on the type of violent incident. Medical records may be required to be produced to the court in legal proceedings, including civil and/or criminal proceedings against an alleged perpetrator. As such they will be used as evidence in the court proceedings. Therefore, they should represent an accurate, detailed and factual record of the health care worker's observations. Where there are physical injuries, photographic evidence may be an important part of this documentation.
- You should also document any event within the health service that causes harm to a colleague or yourself. In most states and territories of Australia it is a legal requirement under workers' compensation legislation that such documentation be made of work-related injuries, illnesses and dangerous events. Further, there may be contractual requirements placed by insurance companies on health services that require such documentation. These records may be used in legal proceedings as an account of reported incidents or for specific purposes such as workers' compensation/ rehabilitation or insurance if a worker has been the injured party.
- This tool will help you to ensure that you record harm resulting from violence for clients, colleagues or yourself in a way that meets the requirements of your profession, your organisation and the law.

This tool does not give guidance on the collection of evidence for forensic purposes. As the outcome of proceedings may rest on evidence, examination for forensic purposes should be carried out by someone who has the authority and the experience or guidance to carry out the examination. In cases where physical examination as part of assessment of the client's injuries may interfere with the evidence, contact your local police (for criminal cases), the Rape Crisis Centre (for sexual abuse) or other relevant organisations to obtain guidance on how to proceed and who should carry out the examination. Remember that the client's welfare is the primary concern.

Where can you get further information?

If you would like more information, refer to the resources and references listed in Part A of this manual. Chapter 2 provides more detailed information on assessing and documenting the situation and providing a supportive environment for your client during assessment. Chapter 4 includes discussion of documentation of occupational violence and Chapter 5 provides details on who to contact for information about legal obligations in your state or territory.

This tool is designed to complement the other tools in the toolkit to guide you in putting the theory outlined in Part A into practice.

SECTION 1 – WHAT SHOULD BE DOCUMENTED AND HOW?

What documentation is needed when a client has been affected by violence

- When a client who has been affected by violence comes into the clinic, you are obliged to take clear, accurate and objective case notes that include a description of the incident and injuries. Section 2.1 of Part A of this manual provides information on assessing and documenting the situation and providing a supportive environment for your client during the assessment. The template for case notes provided in Section 2 of this tool outlines the basic information that should be collected during the consultation.
- Body maps are used in addition to the client's case notes to record injuries in greater detail. Body maps are provided in Section 2 of this tool. Diagrams of genitals are also provided as these allow injuries to the genitals to be recorded in detail.
- It is likely that violence will result in psychological effects as well as physical injury. The form provided in Section 3 will guide you in making observations and asking questions. Anyone with significant psychological problems will need to be assessed more thoroughly by a mental health practitioner (for information on relevant local services contact Just ask on 1300 13 11 14)
- Photographic records may also be a part of documentation of injuries (see Section 5).
- Once completed, all documentation should be included in the client's file and treated with confidentiality. Body maps and photos form part of the client's clinical notes, along with the case notes, so the same confidentiality and privacy requirements apply to them as apply to the written notes.

What documentation is needed when an incident occurs in the workplace?

- Any form of violence that occurs in the workplace must be recorded. Standard procedure is for an incident report form to be completed and submitted to management. Additional documentation of injuries (eg body maps or photographs) or of psychological effects can be attached to the incident form.
- Remember that violence includes threatening behaviour and verbal abuse. If you or a colleague have been threatened by a client or fellow worker, an incident report should be completed even though you may be physically unharmed. Any behaviour within the workplace that offends, humiliates or intimidates you should also be reported. If you become aware that a fellow worker may be a perpetrator or victim of violence you should notify your manager.
- Once completed, a copy of documentation of the incident should be given to your manager, signed by them and a signed copy returned to you. Retain your original and follow-up if you do not receive the signed copy from your manager.

SECTION 2 – HOW DO YOU DOCUMENT THE EFFECTS OF VIOLENCE?

This section gives an example of how injuries resulting from violence can be documented by providing sample case notes, examination reports and body maps. It also includes forms and body maps (pages 106 to 111) which can be copied for use in your organisation or which may provide ideas for improving your organisation's current forms.

SAMPLE CASE NOTES

Date and time	11/5/2002 2310
Name	William Smith
DOB	12/8/1985
Address	8 Kirk Road
Next of kin	Parents

Incident

Day, date and time	Saturday, 11/5/2002, approx 2145
Description of incident (include preceding events, weapons involved etc)	Drinking with older cousin. Argument. Cousin picked up a knife and stabbed him as he turned to get up and run. Friends present – brought him in and contacted clinic staff. Cousin ran off.
Where incident took place	8 Kirk Road
Injury suffered	Wound left loin (see body map)

Examination

Severe local pain, but not shocked. Wound left loin (see attached body map). Minimal external bleeding. No cough, dyspnoea.
P92, BP 140/20. Normal AE R+L
Abd soft. Local spasm in injured muscles.
Rx given IM morphine 10mg, IV 2.5mg for pain for better evaluation of wound.
Probed 6 cm track, mainly subcutaneous and IM
No evidence of peritoneal penetration

Treatment

A/A – analgesia
observation
?evacuation (probably safer in a.m. and not immediately required)
?IVT – no shock/severe haemorrhage
oral fluids – water only

Other documentation of harm resulting from incident

Body maps	See attached
Psychological effects	
Photographs	Taken on arrival at clinic (45 minutes after episode) and included in file

SAMPLE CASE NOTES (CONTINUED)**Other requirements**

Legal issues	<i>Mandatory reporting may be required as client is under 18 – check with manager about state or territory legislation and if required inform relevant authority Police contacted. Will investigate tomorrow. ETA 10.30 am</i>
Safety issues	<i>Discussion with family Cousin (James Smith) violent with EtOH ? Community support</i>
Staff issues	<i>Debriefing of staff on same day</i>
Personal care	<i>Discussed with Julie Green</i>

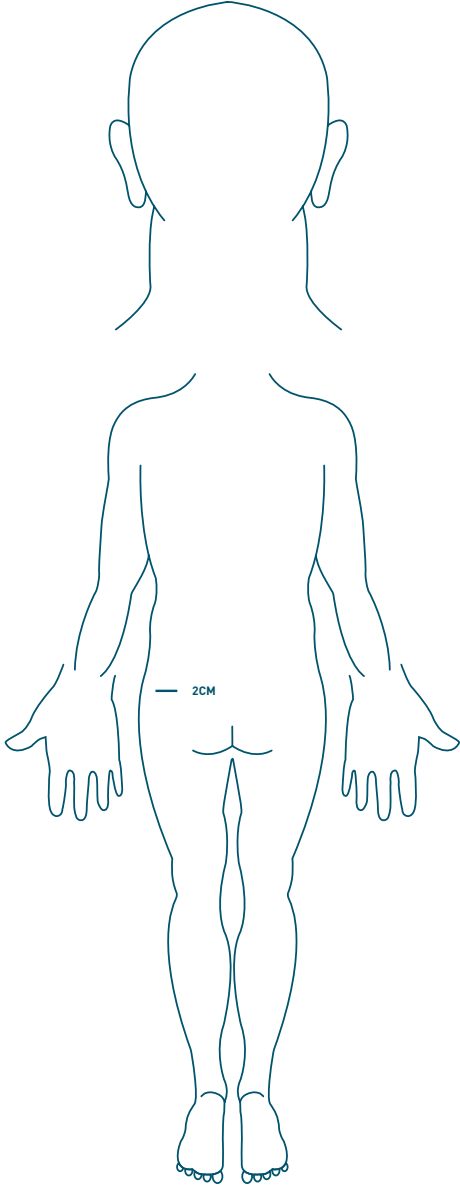
Any other relevant information

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Administrative

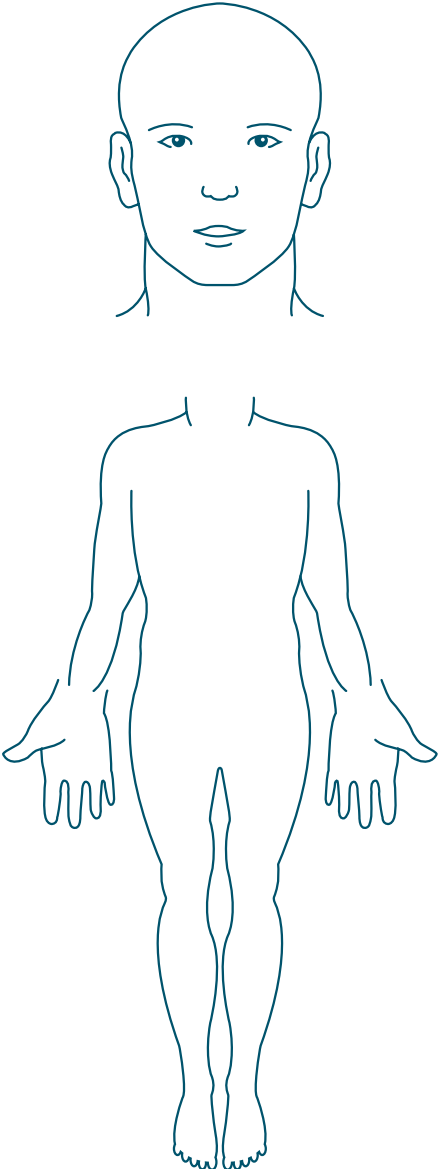
Person completing form:	<i>Dr John Highland</i>
Signature:	<i>signed</i>
Date:	<i>11/5/2002</i>

SAMPLE EXAMINATION REPORT

<p>Surname <i>Smith</i></p>	<p>Other names <i>William</i></p>
<p>Appearance</p> <p>Describe the individual's physical presentation including clothing and hygiene. Be sensitive to different social or cultural norms.</p> <p><i>Client is in severe pain which limits his movement.</i></p> <p><i>Arrived at clinic wearing a brown checked shirt with top 3 buttons missing and signs of tearing where buttons were. Jeans are cut over wound and stained with blood 10cm around tear.</i></p>	<p>Indicate location, size (in cm) and type of findings</p>  <p style="text-align: center;">Posterior</p>

continues

SAMPLE EXAMINATION REPORT (CONTINUED)

Name <i>William Smith</i>		Date <i>11 May 2002</i>
Normal	Abnormal (specify)	Indicate location, size (in cm) and type of findings
Face		 <p style="text-align: center;">Anterior</p>
Mouth		
Throat		
Hands		
Feet		
Legs		
Thorax (Anterior)		
Thorax (Posterior)		
Abdomen (Anterior)		
Abdomen (Posterior)	<i>Wound left loin 2 cm, horizontal, shelves as if slightly upward penetration. Clean incision.</i>	
Buttocks		

Case notes

Date and time	
Name	
DOB	
Address	
Next of kin	

Incident

Day, date and time	
Description of incident (include preceding events, weapons involved etc)	
Where incident took place	
Injury suffered	

Examination

--

Treatment

--

Other documentation of harm resulting from incident

Body maps	
Psychological effects	
Photographs	

Other requirements

Legal issues	
Safety issues	
Staff issues	
Personal care	

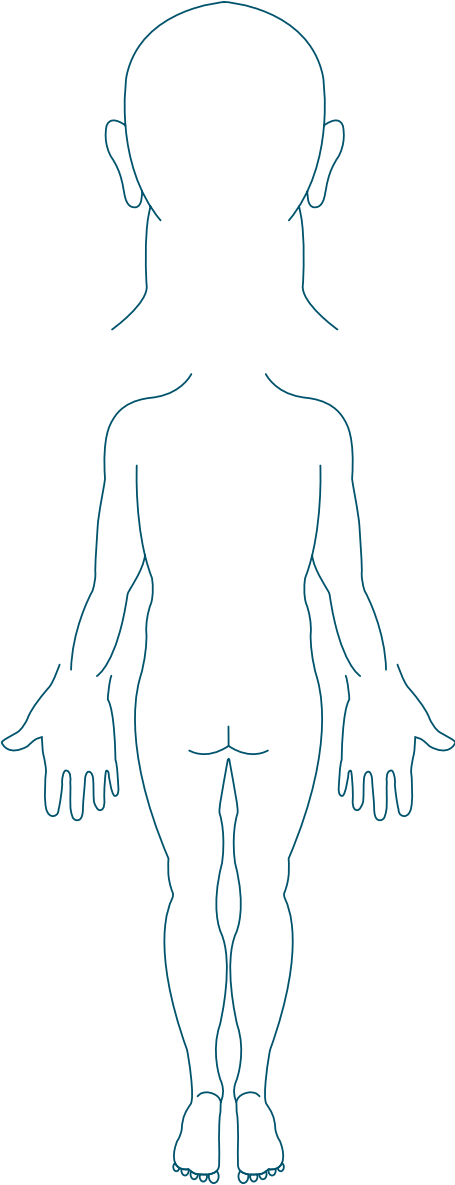
Any other relevant information

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Administrative

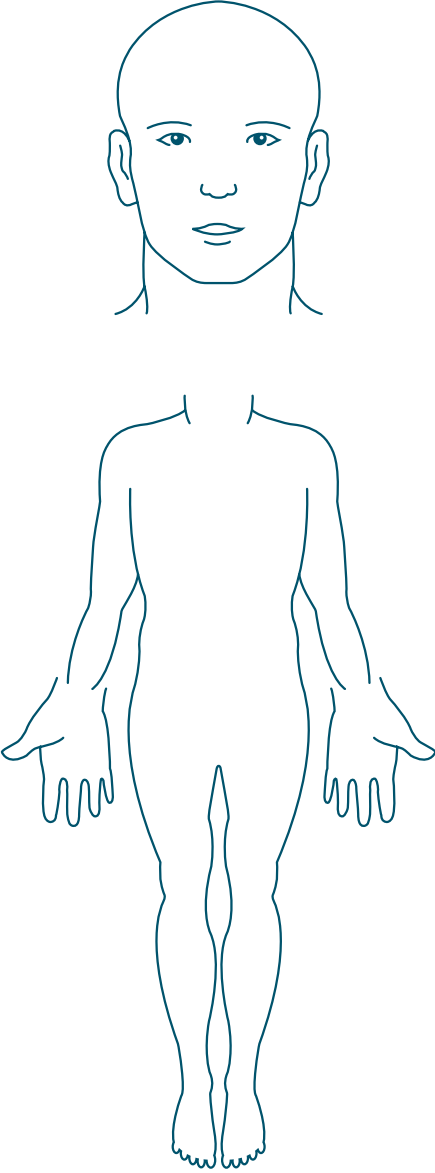
Person completing form:	
Signature:	
Date:	

EXAMINATION REPORT

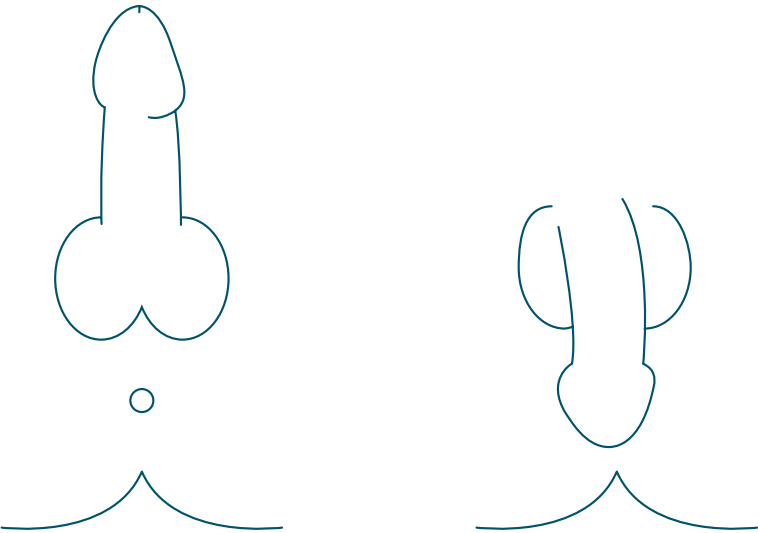
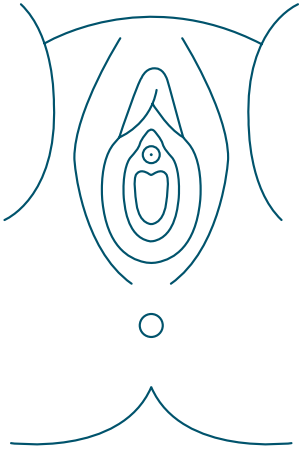
Surname	Other names
Appearance	<p data-bbox="676 499 1168 528">Indicate location, size (in cm) and type of findings</p>  <p data-bbox="882 1790 973 1818">Posterior</p>

continues

EXAMINATION REPORT (CONTINUED)

Name		Date
Normal	Abnormal (specify)	Indicate location, size (in cm) and type of findings
Face		 <p style="text-align: center;">Anterior</p>
Mouth		
Throat		
Hands		
Feet		
Legs		
Thorax (Anterior)		
Thorax (Posterior)		
Abdomen (Anterior)		
Abdomen (Posterior)		
Buttocks		

GENITAL EXAMINATION

Name:	Date:
	
	

SECTION 3 – ASSESSMENT OF PSYCHOLOGICAL STATE*

<p>Appearance</p> <p><i>Simply describe the individual's physical presentation: clothing, hygiene etc.</i></p>	
<p>Behaviour</p> <p><i>Briefly describe the individual's behavioural style, including agitation and any unusual or inappropriate behaviour.</i></p>	
<p>Conversation</p> <p><i>Describe both the content of conversation, perhaps with some quotes, as well as the form, which includes the rate of conversation, as well as the logic, or otherwise of thought processes.</i></p>	
<p>Affect and mood</p> <p><i>Note the individual's mood level, variability, range, intensity and appropriateness.</i></p>	
<p>Perceptual abnormalities</p> <p><i>Note any psychotic symptoms, or other perceptual abnormalities, including hallucinations and delusions. These perceptual abnormalities can occur in any of the five senses.</i></p>	
<p>Cognition</p> <p><i>Describe orientation, memory and attention, ability to concentrate and ability to follow instructions.</i></p>	
<p>Self harm or harm to others</p> <p><i>Comment on any suicidal or homicidal ideas, beliefs or feelings. If necessary, refer for assessment of suicidal behaviour.</i></p>	
<p>Insight</p> <p><i>Assess the individual's insight into his or her psychological state.</i></p>	
<p>Judgement</p> <p><i>Assess the individual's level of judgement, in particular regarding safety issues.</i></p>	
<p>Rapport</p> <p><i>Briefly comment on how you believe the interaction was between yourself and the individual, in particular how the individual made you feel.</i></p>	

* This section is adapted from: Yellowlees P (1998) Psychiatric assessment in community practice. *Medical Journal of Australia Practice Essentials*: 2-7
©Copyright 1998, The Medical Journal of Australia

SECTION 4 – HOW DO YOU DOCUMENT OCCUPATIONAL VIOLENCE?

This section gives an example of how occupational violence should be documented. It provides a sample incident report form and includes an incident report form (pages 114 to 115) which can be copied for use in your organisation or which may provide ideas for improving your organisation's current incident report form.

SAMPLE INCIDENT REPORT FORM

Incident

Day, date and time	<i>Tuesday, 14 December 2001</i>
Description of incident (include preceding events, weapons involved, staff members present etc)	<i>I was cornered by James Knight as I reached for something on the top shelf. He tried to grab me around the waist but I turned and stepped back from him. He called me a "piece of shit" and aimed a kick at my left thigh. He missed but kicked again and got me in the left shin. Kate Castle walked in and James turned away, pretending he needed something from the cupboard.</i>
Where incident took place	<i>Storage room</i>
Injury suffered	<i>Minor bruising on left shin</i>

Treatment

Treatment received	<i>No treatment required</i>
Time off work	<i>Half day</i>

Worker

Name	<i>Helen Bishop</i>
Work address	<i>Chess Health Service</i>
Job, position, department and section (as appropriate)	<i>Aboriginal health worker</i>
Work being done when incident started	<i>Collecting supplies from storage room</i>

Alleged aggressor

Name	<i>James Knight</i>
Age, gender and description (if person is unknown)	
Address	
Relationship to worker or workplace	<i>Registered nurse</i>
Is the aggressor known to have been involved in previous incidents (provide details if yes)	

continues

SAMPLE INCIDENT REPORT FORM (CONTINUED)**Witnesses (if any)**

Name and address (1):	<i>Kate Castle, Registered Nurse, Chess Health Service</i>
Name and address (2):	
Name and address (3):	

Physical environment

Possible contributory factors:	<i>Lack of proper lighting in storage room</i>
Control measures in place at incident:	<i>None</i>
Other control measures which may help:	

Any other relevant information

--

Type of violence

Mark the type(s) of violence that you consider occurred.

<input checked="" type="checkbox"/>	Physical assault	<input type="checkbox"/>	Self-harm	<input type="checkbox"/>	Sexual abuse
<input checked="" type="checkbox"/>	Harassment or bullying	<input checked="" type="checkbox"/>	Discrimination	<input checked="" type="checkbox"/>	Verbal abuse

Administrative

Person completing form:	<i>Helen Bishop</i>
Signature:	<i>signed</i>
Date:	<i>16/12/2001</i>
Completed form sent to:	<i>Brian King, Manager, Chess Health Service</i>

Follow-up and feedback

Name of manager:	<i>Brian King</i>
Debriefing	<i>Helen Bishop counselled by Kate Castle</i>
Other action	<i>Interview with James Knight</i>
Signature:	<i>signed</i>
Date:	<i>21/12/2001</i>

INCIDENT REPORT FORM**Incident**

Day, date and time	
Description of incident (include preceding events, weapons involved, staff members present etc)	
Where incident took place	
Injury suffered	

Treatment

Treatment received	
Time off work	

Worker

Name	
Work address	
Job, position, department and section (as appropriate)	
Work being done when incident started	

Alleged aggressor

Name	
Age, gender and description (if person is unknown)	
Address	
Relationship to worker or workplace	
Is the alleged aggressor known to have been involved in previous incidents (provide details if yes)	

INCIDENT REPORT FORM (CONTINUED)**Witnesses (if any)**

Name and address (1):	
Name and address (2):	
Name and address (3):	

Outcome (describe what happened after the incident)

--

Any other relevant information

--

Type of violence

Mark the type(s) of violence that you consider occurred.

<input type="checkbox"/>	Physical assault	<input type="checkbox"/>	Self-harm	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	Harassment or bullying	<input type="checkbox"/>	Discrimination	<input type="checkbox"/>	Verbal abuse

Administrative

Person completing form:	
Signature:	
Date:	
Completed form sent to:	

Follow-up and feedback

Name of manager:	
Debriefing	
Other action	
Signature:	
Date:	

SECTION 5 – HOW DO YOU COLLECT PHOTOGRAPHIC EVIDENCE?

When there are physical injuries, photographic documentation can be useful in addition to describing the injuries in case notes and using body maps. Consent should always be sought before any photos are taken. A camera (such as a Polaroid camera that produces photos instantly) may be needed on site to take photos for file notes. If taken by the health service, photos must be signed and dated by the senior medical practitioner.

Checklist for obtaining photographic evidence	Yes	No
Has the client been properly informed and given consent for photos to be taken?		
Have you photographed the sites of all injuries?		
Were the photos taken immediately?		
If not taken immediately, have you recorded in the case notes how long after the episode the photos were taken?		
Are photos dated and have they been verified and signed by the appropriate person?		

Tool 4 How you can develop and implement a policy on occupational violence

What is in this tool?

- *Section 1* describes the purpose of a policy and the process of its development, implementation and review.
- *Section 2* lists areas that should be addressed in a policy on occupational violence.
- *Section 3* provides a sample policy on occupational violence and a template to assist you in preparing a policy for your organisation.
- *Section 4* describes ways of ensuring that the policy makes a difference, including developing procedures, monitoring and review.
- *Section 5* includes an example of how the information in this tool can be put into practice.

Why should you read and use this tool?

- Whatever the size of an organisation, a written policy on occupational violence is an important step in demonstrating organisational, management and employee commitment to addressing this health and safety issue. The policy will inform all staff about what behaviour is considered to be unacceptable in the workplace and ensure that they are aware of their roles and responsibilities. It will also encourage workers to report violent incidents.
- For organisations where a policy on occupational violence is already in place, the information in this tool can provide guidance when the policy is reviewed. It can also help your organisation make sure that all relevant procedures have been developed.
- Workers benefit from a policy on occupational violence as such a document brings this issue out into the open, thereby promoting awareness and action throughout the organisation – from senior management through worksite managers and supervisors to new workers. The enhanced awareness leads to actions to address this hazard which in turn translates into a reduction in the risk of exposure to violence. For example, procedures developed to implement the policy serve to guide workers in their daily practice and help them to meet their responsibilities.

Where can you get more information?

If you'd like more information, refer to the resources and references listed at the end of Chapter 4 in Part A of this manual.

Consult your employer about any existing policy and about organisational guidelines on policy and procedure development. Contact your state/territory occupational health and safety authority for information or guidelines on developing policies on occupational health and safety issues.

This tool is designed to complement the other tools in the toolkit to guide you in putting the theory outlined in Part A into practice.

Sources

This tool has been developed by the working party based on their expertise with material kindly provided by New England Area Health Service and the ACT Public Service Occupational Health and Safety Unit.

SECTION 1 – WHAT ARE POLICIES AND PROCEDURES?

A *policy* is an organisation's statement of its goal and objectives in a particular area. The actual content of the policy will depend on the organisation and its particular circumstances such as size. A policy should provide broad direction on an issue, show commitment to making improvements in the area addressed by the policy, describe arrangements to achieve the policy's objectives and outline the roles and responsibilities of managers and employees. A policy will also include or refer to *procedures*, which are explicit directions for staff about what to do to implement policy.

The process of policy development is outlined below.

Identify the need for policy

Managers and employees agree:

- who will be responsible for the process (eg a working group set up for the purpose)
- what procedures will need to be developed to support implementation of the policy (see Section 4)
- how employees and the community can be involved in the process
- what resources and advice are available
- when the policy should be completed.



Develop the policy and procedures

- A policy answers the questions who?, what? and how?
- Procedures answer the questions who?, what?, when?, where?, why? and how?
- The policy and procedures are written in language that is clear, concise and to the point.
- Collaboration with employees and the community is incorporated into all stages of policy development. Collaboration is representative and sensitive to cultural considerations and the needs of key stakeholders. Involving stakeholders engenders ownership of the policy.
- Ethical implications of the document are identified and documented.
- A senior manager or director and a representative of the employees involved in the policy's preparation sign the document.
- A date for review of policy and procedures is set.



Implement the policy

- The policy is launched and stakeholders recognise its importance.
- Procedures developed to support the policy are put into use.
- Communication ensures that the relevant people know about the policy and the procedures.
- The use and effects of the policy and procedures are monitored.
- Revision of the documents is carried out if there are changes in the workplace.



Review the policy

- Regular review of the policy ensures that it remains current and appropriate to the needs of the organisation.
 - Review is initiated by the person who authorised the policy development or who has responsibility for the policy area.
-

SECTION 2 – WHAT NEEDS TO BE INCLUDED IN THE POLICY?

The contents of policies on occupational violence will vary greatly depending on the size and needs of the organisation. In addition to outlining the responsibilities of managers and staff, policies on occupational violence may include:

- a clear statement of the organisation's commitment to preventing and managing occupational violence
- definition of occupational violence in clear, precise language
- discussion of incident reporting, including description of the consequences for workers who commit acts of violence
- making a commitment to provide support services to workers who are affected by violence
- offering a confidential counselling service to allow employees with personal problems to seek help
- making a commitment to fulfil the violence prevention training needs of different levels of personnel within the organisation
- training on legal issues surrounding occupational violence, workers' compensation and occupational health and safety requirements.

The sample policy on the following page illustrates how these matters might be addressed in a policy for a medium-sized health service. A template is also included that can be used when drafting a policy on occupational violence for your organisation.

SECTION 3 – SAMPLE POLICY ON OCCUPATIONAL VIOLENCE

Aim	
<i>The management committee of this organisation recognises its obligation to provide a safe work environment and to protect employees and clients from harm. It is the policy of this organisation to aim to achieve better practice in the prevention and management of occupational violence.</i>	
Definition of occupational violence	
<i>For the purposes of this policy, occupational violence is defined as violence between workers, violence against workers by people not employed by the organisation, and random acts of violence that affect the workplace. This includes, but is not limited to, physical assault, sexual abuse, self-harm, harassment, bullying, verbal abuse and discrimination.</i>	
Responsibilities of managers	
<p><i>In this organisation:</i></p> <ul style="list-style-type: none"> • <i>a risk management approach will be taken towards occupational violence (including hazard identification, risk assessment, risk control and monitoring and review)</i> • <i>staff will be provided with information to increase their awareness of violence</i> • <i>staff will be encouraged to report all incidents of violence and incident report forms will be reviewed to identify the nature and extent of the problem and identify areas of particular risk</i> • <i>staff will be provided with guidance on when occupational violence must be referred to other authorities (eg police or occupational health and safety authority)</i> • <i>training will be provided to all new and existing staff to help them to follow relevant procedures, identify potentially violent situations, diffuse a potentially threatening situation, manage their own anger and recognise indicators of traumatic stress reactions</i> • <i>safety issues for staff working alone or after hours will be addressed</i> • <i>the work environment (including areas outside the organisation where employees carry out their work) will be assessed for factors that may increase the risk of violence and changes made to reduce the risk where possible.</i> 	
Responsibilities of employees	
<i>Employees have a responsibility to themselves and their colleagues to follow safe work practices and to ensure that they are adequately trained to perform their duties.</i>	
Incident reporting	
<p>Reporting of violence against workers, whether or not harm occurs, is a positive contribution to safety planning. Any act of violence committed in the workplace or against an employee of the organisation while they are carrying out their work must be reported. All reports will be treated confidentially and investigated. Disciplinary action will be taken after each proven incident and discharge will occur after significant aggressive behaviour. <i>(See procedure on incident reporting)</i></p>	
Immediate response to violent episodes	
<p><i>Where possible personal protection will be provided to staff (eg duress alarms, security doors).</i></p> <p><i>New and existing staff will be trained in following the procedure on responding to incidents of violence in the workplace.</i></p>	
Recovery and review	
<p>In the event of a violent episode that affects or has the potential to affect the physical or mental health of workers, initial counselling and support services will be provided to employees and immediate family members. Consideration will also be given to the provision of back-up staff if some staff are receiving treatment so that existing staff do not carry an excessive workload. <i>(See procedure on recovery and review)</i></p>	
Review of the policy: <i>This policy will be reviewed annually as from date of endorsement.</i>	
Signed: <i>Signature (Health Service Manager)</i>	<i>Signature (Employee representative)</i>
Date: <i>17 June 2002</i>	Review date: <i>17 June 2003</i>

Policy on occupational violence

Aim	
Definition of occupational violence	
Responsibilities of managers	
Responsibilities of employees	
Incident reporting	
Immediate response to violent episodes	
Recovery and review	
Review of the policy:	
Signed:	(Health Service Manager) (Employee representative)
Date:	Review date:

SECTION 4 – HOW DO YOU MAKE THE POLICY WORK?

Implementation

The main way of implementing policy is through developing and putting into use locally relevant procedures. Having procedures that cover the areas outlined below will help your organisation to take a consistent approach to preventing violence and managing it effectively when it does occur. It will also assist in gathering information on occupational violence to inform future planning. Issues that should be covered are:

- caring for abused or threatened clients (eg properly documenting injuries, using the referral network and reporting to police or other authorities if required)
- incident reporting (see Section 4.2 and Tool 3)
- meeting legal reporting requirements (see Chapter 5)
- support (eg counselling) for workers who have been affected by violence
- making compensation claims
- management of incidents of violence in the health service
- working alone and after hours
- referral to appropriate community agencies (eg police, mental health services)
- containing and, where practical, defusing situations until referral agencies can respond (see Tool 2)
- recovery and review, including appropriate counselling for traumatised workers.

Monitoring

Ways of monitoring the policy may range from carrying out spot checks to regular review of all aspects of occupational health and safety procedures. Reports of all violent episodes should be examined for trends and patterns in frequency or type.

Revision

The policy may need to be revised if the type of work changes, new potential hazards are introduced into the workplace, or if there are changes of staff or duties. Revision may also be necessary if new regulations, codes of practice or guidelines are published which are relevant to the activities of the organisation.

Communication

Depending on the size of your organisation and the resources available, ensuring that policies and procedures are acted upon and that the relevant people are informed about them might involve:

- creating a manual including the policy and procedures (this can be as simple as photocopying the papers and putting them in a folder) and distributing it to all staff
- providing staff with guidance on following the policy and procedures (you could do this by conducting a training seminar or putting together an information sheet)
- including information on the policy and procedures in orientation for all new staff
- informing the community of the policy and procedures (eg through display of the aim of the organisation's policy in public areas of the health service)
- informing other relevant organisations (eg referral agencies).

Other policies

Your organisation's policy on violence is likely to be complemented by other policies in place such as policies on:

- training – maintaining up-to-date skills among employees so that they are informed about potential hazards and equipped to take appropriate actions to protect themselves and fellow workers
- critical incident management – preparing responses in the event of a violent episode
- liability, insurance and compensation – making arrangements to protect the interests of the health service and employees should violent episodes cause them harm
- business continuity – allowing for service provision to continue when violent events close down the health service
- confidentiality and anonymity – ensuring that the privacy of workers involved in violent episodes is protected.

SECTION 5 – ACTION CHECKLIST

Have you?	Yes	No
Gone through the checklists at the end of each chapter in Part A of the manual to identify specific areas where policies and procedures are required for your organisation?		
Worked out the roles and responsibilities of health care providers (doctors, health workers, nurses) and established organisational procedures to meet these responsibilities?		
Worked out how to meet occupational health and safety obligations (as required in your state/territory) about the nature/type/degree of exposure to occupational violence and who is responsible?		
Checked that policies and procedures are developed in line with relevant national and state/territory legislative requirements?		
Checked that relevant national and state/territory legislative requirements are incorporated into procedures where appropriate?		

Tool 5 How you can include occupational violence in your risk management process

WHAT IS IN THIS TOOL?

- *Section 1* discusses the process of risk management and the steps involved.
- *Sections 2 to 6* describe the five steps of the process.
- *Section 7* includes forms to guide you in keeping a record of your actions.

WHY SHOULD YOU READ AND USE THIS TOOL?

- The process of managing risks to the health and safety of workers is required as standard practice for all Australian workplaces.
- Taking a risk management approach to providing a safer working environment for health care workers is a sound cost-benefit strategy, when the costs associated with high turnover of staff and the potential for occupational health and safety claims are considered.
- Proper documentation of risk management shows that your organisation has been actively working to discharge its duty of care to ensure workplace health and safety.
- Every member of the health service has a role to play in the organisation's management of risk, from senior executives through to new recruits.
- A risk management approach to violence can be a useful way for each health care worker to become aware of hazards that may affect them in the course of their work and to make changes to improve their safety.

This tool describes ways of managing exposure to the risk of injury or psychological harm from violence as part of the broader risk management approach required by legislation.

WHERE CAN YOU GET MORE INFORMATION?

If you'd like more information, refer to the resources and references listed at the end of Chapter 4 in Part A of this manual. Contact the relevant body to make sure that your approach to risk management and its documentation meet legislative requirements in your state or territory.

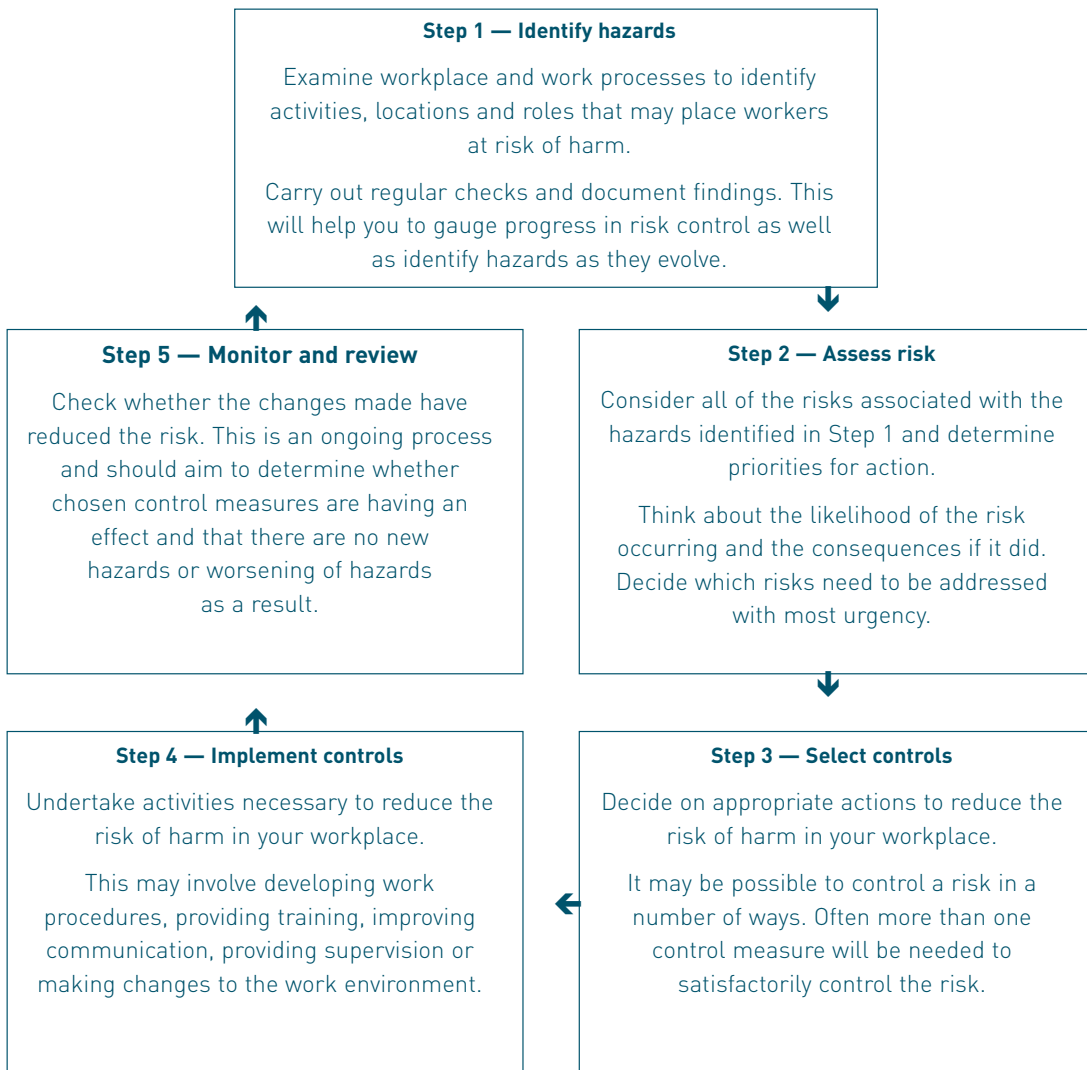
This tool is designed to complement the other tools in the toolkit to guide you in putting the theory outlined in Part A into practice.

SOURCE

Information in this tool is adapted from: Queensland Department of Employment, Training and Industrial Relations (2000) *Workplace Health and Safety Risk Management Advisory Standard 2000*.

SECTION 1 – WHAT IS RISK MANAGEMENT?

As an employer or person in control of a workplace, you are required to take a risk management approach to ensure workplace health and safety. This means that you should have a structured process to identify potential hazards in the workplace and take action to eliminate or reduce the risk of harm to workers. There are five steps to the risk management process as outlined below.



Risk management is an ongoing process and should be carried out:

- as soon as possible if it has not been done before
- when a change occurs (eg changes to work procedures)
- after an incident or near miss
- at regular intervals depending on the nature of the risks and the degree of change likely in work activity.

The way in which risk management is implemented will depend on the nature of your workplace. Although the steps of the process are described separately here, you may find that there is some overlap.

DOCUMENTATION

Keeping records of the process will help you to keep track of what you have done and are planning to do. The detail and extent of recording will depend on the size of the workplace and the potential for major health and safety issues. However, your records should show that you have been actively working to ensure workplace health and safety. If there are specific record keeping requirements for certain workplace hazards in your state or territory, you will need to meet these.

SECTION 2 – WHAT IS HAZARD IDENTIFICATION?

The first step of the risk management process is to identify the things in your workplace that have the potential to cause harm. The desired outcome of this step is a list of hazards and associated risks, which will form the basis of your work in following the steps on page 126.

In this case, the hazards are the three forms of occupational violence identified in the Introduction to this manual:

- violence between workers
- violence against workers by people not employed by the organisation
- random acts of violence.

However, the hazard of occupational violence is not static or easy to identify like a noisy machine or a slippery step. Accordingly, it is important to consider what might lead to violence in the workplace or during a work-related activity. To guide your efforts it may be useful to consider the work processes and workplace through three complementary views – activity, location and role. Circumstances or factors that may relate to occupational violence are likely to include:

- poor security
- staff working alone on the premises, especially at night
- location of the organisation in an area where there are high levels of violence
- high levels of stress among workers
- the design of the work environment (eg consultation rooms from which there is only one route of escape and no communication with people beyond the room).

There are a number of activities that can help you gain an understanding of violence in your workplace or relating to a work process:

- examining workplace accident and injury records and reports to see what is being reported and if there are any trends (eg particular work tasks, work processes or locations that are related to higher levels of violence)
- talking with workers, supervisors and managers to learn about their experiences and to understand their needs
- talking with individuals who have experienced occupational violence in similar work settings and work processes
- examining the effectiveness of the security devices presently in use

- talking with similar organisations (location, function and size) such as local businesses and community groups to identify trends and learn about their experiences with occupational violence, including how they are managing the problem
- watching people working to better understand work processes.

You don't need to look at all these areas at the same time but could try to collect the information when you have the chance.

The form on page 136 of this tool can be used to record details of hazards identified in your workplace. You may find that each hazard relates to a series of risks. Use numbering (eg you can list risks R1a, R1b for hazard H1, risks R2a, R2b for hazard H2 etc) to create a chain of evidence of action.

SECTION 3 – WHAT IS RISK ASSESSMENT?

Once you have gathered information about the hazards in your workplace, you will need to work out which risks potentially have the greatest consequences. To do this:

- consider the number of people exposed to each hazard and the duration of the exposure (risk = hazard + exposure)
- determine the nature and source of the potential violence and what category of occupational violence it comes under
- determine the probability and potential consequences if the identified hazard took place
- use the information gathered to assess the **likelihood** and **consequences** of each potential incident of violence.

Use a risk priority chart to translate the estimated likelihood and potential consequences of an incident into a level of risk that can be attributed to the hazard. The risk rating for each hazard is only useful for comparing the different hazards you have identified and thereby determining the order in which hazards should be addressed.

The *likelihood* of violence occurring due to a particular situation (identified hazard) in the workplace is:

Very likely	if it could happen frequently
Likely	if it could happen occasionally
Unlikely	if it could happen, but is rare
Very unlikely	if it could happen, but probably never will.

The *consequences* of likely injuries if violence were to occur due to a particular situation (identified hazard) in the workplace are:

Extreme	if it would result in death, permanent disablement
Major	if it would result in serious bodily injury
Moderate	if it would result in casualty treatment
Minor	if it would result in first aid only, with no lost time from work.

The form on page 137 includes a risk priority chart and can be used to document your assessment of risk.

SECTION 4 – HOW DO YOU SELECT RISK CONTROL MEASURES?

Step 3 of the process involves deciding on control measures to manage exposure to identified risks. The control measures selected should adequately control exposure to the hazard, not create another hazard and allow workers to do their work without undue discomfort or distress.

The ideal solution is to eliminate the hazard. If this is not possible, prevent or minimise the exposure by using a safer alternative or redesigning work processes. The table below outlines a hierarchy of control measures.

Description	Example
<i>Eliminate the hazard</i>	
The most effective means of risk control as removing the reason for violence removes the risk.	<ul style="list-style-type: none"> • Have no cash or potentially appealing drugs at the health service after dark or make sure the clinic is properly secured.
<i>Use safer alternative</i>	
When the hazard cannot be removed or eliminated then alternatives that may be safer need to be considered.	<ul style="list-style-type: none"> • 'Buddying' arrangements between health and community workers in compatible community services to reduce or eliminate the need to work alone.
<i>Use engineering solution</i>	
When designing or 'fitting out' a building for use as a health centre, or planning a worksite or workstation, the incorporation of measures that could reduce the risk of violence needs to be considered.	<ul style="list-style-type: none"> • Installation of security doors and lighting • A secure room and physical barriers • Alarm and communication systems • Comfortable seating and calming surrounds • Play areas for children.
<i>Reorganise work and provide training</i>	
<p>The reorganisation of work processes coupled with training can be an effective means to decrease the level of risk of occupational violence. This is a broad method of control that could foster considerable innovation and ongoing worker participation.</p> <p>Training should be a key component of any occupational violence reduction program. It is important that the training, like all other interventions, is closely linked with the hazards identified.</p>	<ul style="list-style-type: none"> • Job rotation and rostering/relief support to reduce employee exposure to stressful situations. • Installation of surveillance equipment and signage to promote its presence and capacity. • Establishment of communication systems for emergencies and to share information about ongoing or potential situations. • Clear policies and procedures relating to violence and how it should be dealt with. • Administrative controls or barriers such as client sobriety requirements or procedures for contacting health care workers outside work hours.
<i>Supply personal protective equipment (PPE)</i>	
This is the least effective means of risk reduction. Instead of the hazard being acted upon (eliminated, reduced etc), the worker is required to wear/use PPE to increase protection from the hazard. The use of PPE should be a temporary measure or used in combination with other interventions.	<ul style="list-style-type: none"> • Capsicum spray • Personal alarms

SECTION 5 – HOW DO YOU IMPLEMENT CONTROL MEASURES?

Step 4 of the risk management process involves putting the selected control measures in place. This includes carrying out any activities that are needed to allow the measures to function effectively. This may involve:

- developing work procedures in relation to the new control measures and defining manager, supervision and worker responsibilities
- communicating with workers and others about the control measures that are to be implemented and the reasons for the changes
- providing any training needed for the control measures to be effective (eg instruction in use of duress alarms)
- providing supervision or monitoring to ensure that the control measures are being used
- determining any maintenance requirements to ensure ongoing effectiveness of the new control measures.

SECTION 6 – MONITORING AND REVIEW

The final step in the process of risk management is to monitor and review the effectiveness of the control measures. You can use the questions below to guide you in determining whether:

- chosen control measures have been implemented as planned
 - Are the chosen control measures in place?
 - Are these measures being used?
 - Are these measures being used correctly?
- chosen control measures are working
 - Have the changes made to control the risk of exposure to violence had the intended results?
 - Has exposure to the assessed risks resulted in the worsening of any existing problems?
- there are new problems
 - Have implemented control measures resulted in the manifestation of any different health and safety problems?
 - Have implemented control measures resulted in the worsening of existing problems?

To answer these questions you can:

- consult with workers, supervisors and health and safety representatives
- measure workers' exposure
- monitor incident reports.

A date should be set for review of the risk management process.

SECTION 7 – DOCUMENTING RISK MANAGEMENT

The following pages provide a series of forms for the documentation of the risk management process. A set of forms has been completed to provide an example of how the process of reducing the risk of exposure to violence might be carried out in a health service.

Each time the process of risk management is carried out a new set of forms should be used. You may need more than one copy of the form documenting one step of the process. All of the forms should be dated, signed by the manager of the health service and filed together (eg *Risk Management Process June 2002*) for future reference and as documentation of an active approach to workplace health and safety.

STEP 1: HAZARD IDENTIFICATION

Name of organisation: <i>Chess Health Service</i>			Workplace/workgroup: <i>NA</i>		
Information collected by: <i>Helen Bishop</i>			Date: <i>31 March 2002</i>		
Activity/ location/ role	Hazard	Hazard reference	Related risks	Risk reference	People/groups affected
<i>Night time community call out (activity)</i>	<i>Occupational violence – against workers by people not employed by the organisation</i>	H1	<i>Likelihood of harm to worker called out at night to incident in community</i>	R1a	<i>Health care worker rostered to make night time community call outs</i>
	<i>Occupational violence – random acts of violence</i>	H2	<i>Likelihood of harm to worker while travelling to/from night call-out to incident in community</i>	R2a	<i>Health care worker rostered to make night time community call outs</i>
<i>Working in Consultation room 1 (location)</i>	<i>Occupational violence - against workers by people not employed by the organisation</i>	H3	<i>Likelihood of harm to worker as there is no way to escape aggressive individual or raise alarm</i>	R3a	<i>All health care workers conducting consultations in room 1</i>
<i>Aboriginal health worker (role)</i>	<i>Occupational violence – violence between workers</i>	H4	<i>Likelihood of acts of discrimination by other staff members</i>	R4a	<i>Aboriginal health workers and other workers</i>
	<i>Occupational violence - against workers by people not employed by the organisation</i>	H5	<i>Likelihood of acts of discrimination by clients</i>	R5a	<i>Aboriginal health workers and other workers</i>

STEP 2: RISK ASSESSMENT

Name of organisation: <i>Chess Health Service</i>			Workplace/workgroup: <i>NA</i>	
Information collected by: <i>Helen Bishop</i>			Date: <i>31 March 2002</i>	
Risk Ref No	Likelihood	Consequence	Risk rating (use risk priority chart)	Existing controls (if any)
R1a	<i>Likely</i>	<i>Minor to Moderate</i>	4–5	<i>Nurses use call-in system</i>
R2a	<i>Unlikely</i>	<i>Minor to moderate</i>	5–6	<i>Car travel to destination – arrangements to be met at car, nurses use call-in system</i>
R3a	<i>Likely</i>	<i>Minor to Major</i>	3–5	<i>No controls in place. Most consultations are carried out in room 1. Many clients have mental health or addiction problems. Many are frustrated.</i>
R4a	<i>Unlikely</i>	<i>Minor</i>	6	<i>Formal occupational violence policy and procedures. Annual training in cultural sensitivity. Only one staff member is Aboriginal.</i>
R5a	<i>Very unlikely</i>	<i>Minor</i>	7	<i>Formal occupational violence policy and procedures. Annual training in cultural sensitivity. About 70% of clients are Aboriginal.</i>

Risk priority chart

Consequences				
Likelihood	Extreme	Major	Moderate	Minor
Very likely	1	2	3	4
Likely	2	3	4	5
Unlikely	3	4	5	6
Very unlikely	4	5	6	7

Score	Action
1, 2 or 3	do something about these risks immediately
4 or 5	do something about these risks as soon as possible
6 or 7	these risks may not need immediate attention

STEP 3: RISK CONTROL – DETERMINING APPROPRIATE MEASURES

Name of organisation: <i>Chess Health Service</i>			Workplace/workgroup: <i>NA</i>	
Information collected by: <i>Helen Bishop</i>			Date: <i>5 April 2002</i>	
Risk Ref No	Risk rating	Control ref	Possible control options	Comments
<i>R3a</i>	<i>3-5</i>	<i>C3a-1</i>	<i>Install door in back wall</i>	<i>Expensive as the wall is a brick wall which is the outside wall of facility</i>
		<i>C3a-2</i>	<i>Install glass partition to allow observation from other areas of the building</i>	<i>Consultation room may require privacy and this would reduce effectiveness of this intervention. Cost is thought to be high – but would need to get a quote</i>
		<i>C3a-3</i>	<i>Use consultation room 2 for clients who are known to be aggressive, or are identified as potentially aggressive. Consultation room 2 has rear and front access and duress alarm installed</i>	<i>Consultation room 2 is not as well equipped for emergency situations but does have appropriate features to prevent or reduce potential impact of occupational violence</i>
		<i>C3a-4</i>	<i>Install duress alarms</i>	<i>Low cost option but do we have the staff to respond to alarm?</i>
		<i>C3a-5</i>	<i>Provide training in conflict resolution</i>	<i>De-escalation skills can be effective in preventing violence. Annual refresher courses could be conducted to update skills. Could be part of orientation program</i>
		<i>C3a-6</i>	<i>Supply personal duress alarms</i>	<i>Low cost – could make personal duress alarms standard issue</i>
<p>Comments</p> <p><i>Based on effectiveness and budget – the interventions chosen at this time are the supply of personal duress alarms, installation of duress alarm under consultation desk, training in de-escalation skills and the use of consultation room 2 when clients have been identified as potentially violent.</i></p>				

STEP 4: RISK CONTROL IMPLEMENTATION PLAN

Name of organisation: <i>Chess Health Service</i>			Workplace/workgroup: <i>NA</i>		
Information collected by: <i>Helen Bishop</i>			Date: <i>17 April 2002</i>		
Hazard or risk ref	Control option	Proposed activities	Resources required	Person(s) responsible	Implementation date
<i>R3a</i>	<i>C3a-3</i>	<i>Use consultation room 2 for clients who are aggressive or identified as potentially aggressive.</i>	<i>Team meeting to discuss changes to procedures manual and training in use of consultation room 2 facilities</i>	<i>Team leader</i>	<i>1 June 2002</i>
	<i>C3a-4</i>	<i>Install duress alarms</i>	<i>Alarm and electrician to install alarm. Cost estimate \$350.00. Request for funding to be prepared and submitted to manager</i>	<i>Workplace Health and Safety Advisor</i>	<i>1 August 2002</i>
	<i>C3a-5</i>	<i>Provide training in conflict resolution</i>	<i>Training to be part of annual training program and induction program</i>	<i>Human Resources Manager</i>	<i>1 May 2002</i>
	<i>C3a-6</i>	<i>Supply personal duress alarms</i>	<i>Alarms to be issued to all health care workers rostered at night. Cost is \$100.00 per alarm. Need to determine total number of staff affected and total cost of alarms. Request for funding to be prepared and submitted to manager</i>	<i>Workplace Health and Safety Advisor</i>	<i>1 August 2002</i>
Comments					

STEP 5: MONITORING AND REVIEW

Name of organisation: <i>Chess Health Service</i>			Workplace/workgroup: <i>NA</i>		
Information collected by: <i>Helen Bishop</i>			Date: <i>30 September, 2002</i>		
Control measure			Comments		
Control ref	Associated activities	Review date	Are measures in place?*	Are controls minimising exposure to the risk**	Are there any new problems? #
C2a-3 <i>Use consultation room 2 for clients who are aggressive or identified as potentially aggressive</i>	<i>Team meeting to discuss – 30 May, 2002</i>	<i>1 July 2002</i>	<i>Team meeting held and all staff alerted to new procedures. Review of new procedures scheduled for next staff meeting 30 July 2002</i>	<i>Staff feel change will assist. Will need to review at next staff meeting and after 6 months</i>	<i>None identified at this stage</i>
	<i>Changes to procedures manual, 30 May 2002</i>	<i>15 July 2002</i>	<i>Changes have been drafted for procedures manual. Manual is now under review</i>	<i>Changes are not yet formally in place. Review in 3 months</i>	<i>None identified</i>
	<i>Training in use of consultation room 2 facilities – end of June, 2002</i>	<i>1 August, 2002</i>	<i>All staff have been taken through the features of consultation room 2 by end of June 2002.</i>	<i>Usage of consultation room 2 has not increased. Staff may need training in identifying signs of potential violence.</i>	<i>Refresher/ reminder training will need to be scheduled. New staff will need to be informed of procedure and taken through room. Training in identifying signs of violence is required.</i>
Comments					

* If NO, implement control measures.

** If NO, review decision on control measures.

If YES, decide on control measures.

STEP 2: RISK ASSESSMENT

Name of organisation:			Workplace/workgroup:	
Information collected by:			Date:	
Risk Ref No	Likelihood	Consequence	Risk rating (use risk priority chart)	Existing controls (if any)

Risk priority chart

Consequences				
Likelihood	Extreme	Major	Moderate	Minor
Very likely	1	2	3	4
Likely	2	3	4	5
Unlikely	3	4	5	6
Very unlikely	4	5	6	7

Score	Action
1, 2 or 3	do something about these risks immediately
4 or 5	do something about these risks as soon as possible
6 or 7	these risks may not need immediate attention

STEP 3: RISK CONTROL – DETERMINING APPROPRIATE MEASURES

Name of organisation:			Workplace/workgroup:	
Information collected by:			Date:	
Risk Ref No	Risk rating	Control ref	Possible control options	Comments
Comments				

STEP 4: RISK CONTROL IMPLEMENTATION PLAN

Name of organisation:				Workplace/workgroup:	
Information collected by:				Date:	
Hazard or risk ref	Control option	Proposed activities	Resources required	Person(s) responsible	Implementation date
Comments					

STEP 5: MONITORING AND REVIEW

Name of organisation:			Workplace/workgroup:		
Information collected by:			Date:		
Control measure			Comments		
Control ref	Associated activities	Review date	Are measures in place?*	Are controls minimising exposure to the risk**	Are there any new problems? #
Comments					

* If NO, implement control measures.

** If NO, review decision on control measures.

If YES, decide on control measures.

Tool 6 How your community can become safer

What is in this tool?

- *Section 1* includes a range of suggestions for making your community safer. This includes some ideas for creating safe spaces so that all community members, especially those who are vulnerable to violence, have somewhere to go where they can feel safe. The types of changes that are possible will depend on your community and the role of the health service within it. Ideas for different degrees of change are outlined in this section.
- *Section 2* gives you some ideas on where to start, through workshops within the health service and within the community.
- *Section 3* gives an example of ways in which these ideas can be put into practice.

Why should you read and use this tool?

The information provided in this tool will assist you in working with others to:

- use the health service to raise community awareness about the problem of violence in the community
- provide support and safe spaces for people who are vulnerable to violence
- develop local solutions to problems that contribute to violence (eg discrimination and 'turning a blind eye')
- think of some physical or structural changes that might help make violence less likely to happen in your community.

Where can you get more information?

If you'd like more information, refer to the resources and references listed at the end of each chapter in Part A of this manual (in particular Chapter 6 which includes some examples of local solutions to violence developed by communities across Australia).

This tool is designed to complement the other tools in the toolkit to guide you in putting the theory outlined in Part A into practice.

SECTION 1 – SUGGESTIONS FOR MAKING COMMUNITIES SAFER

Making communities safer isn't just about having shelters and refuges where people can escape to when they are the victims of violence. It's about making the whole community a safer place to live, with people working in partnership to find ways to make violence less likely to happen. The idea is to move away from managing crises as they occur, towards a situation where violence is reduced and there are fewer crises to deal with.

There are many ways in which communities can become safer places. These range from simple measures such as improving access to information and increasing community awareness, through to preventing crime by changing the design of public spaces. The suggestions below aim to give you some ideas, based on strategies that have worked in other places. The first part of the section discusses some things that could be done within the health service. The rest of the section outlines more widespread changes that would require community consultation and involvement.

What can be done within the health service?

LEAD BY EXAMPLE

- It's important that the health service shows the community that it will not tolerate any form of violence or discrimination within the organisation. A policy should be in place to support work towards zero tolerance of violence (see Tool 4). The policy can be displayed in a public area of the service.
- A process for client feedback will help to ensure that zero tolerance of violence is carried through. You could support this by placing information on the display board about complaints processes, so that clients know how to make and follow through with complaints against health care workers who discriminate against them. You could also make it clear that you welcome direct feedback about your service – perhaps by putting a comment box in the waiting area.
- Before you set up a system for feedback and complaints, it is important to discuss as a team how the organisation will respond to any complaints and how any complaints against health care workers will be handled. Check whether there is already a policy on consumer feedback and a procedure for dealing with complaints (especially if you are part of a larger organisation such as a state health service).

INCREASE COMMUNITY AWARENESS

- Information can be used to raise community awareness about the problem of violence and to let people know about support services and other resources. Information can be in the form of posters, pamphlets, information sheets, car bumper stickers, t-shirts, postcards, even beer mats and stubby holders.
- Setting up a display in the waiting room of the health service is a practical, non-threatening way to raise awareness, as well as distribute information and contacts for support on specific issues (eg child abuse, sexual assault).

ACCESS CLIENTS SAFELY

- Making the health service safe is important for you and your clients. This may include restricting access to certain areas, using locks on storage areas, designating 'safe' escape rooms (with telephone or duress alarm), and fitting duress alarms in all rooms of the health service. Workers making community visits can be issued with mobile phones or personal alarms or, where possible, work in pairs. Detailed call-in check systems and pre-planned distress messages may be useful ways to protect staff working outside the workplace.
- When the health service has been the target of violence, it is necessary to protect staff and clients. Putting up obvious barriers (eg barbed wire fences) can create feelings of 'us' and 'them' within the community that may make clients feel excluded or unwelcome. It's important to find ways to be protected without becoming isolated. For example, an enclosed veranda does not look like a barrier, but will allow you to see who is approaching the building and to communicate from a safe area if necessary.

How can people who are vulnerable to violence be supported?

BREAK THE SILENCE

- One of the reasons that some communities stay unsafe is that people 'turn a blind eye' to violence. They might be afraid that they will become a target of violence themselves, or they might feel that reporting will lead to nothing. Violence is often a sensitive issue that communities would rather not acknowledge.
- If groups within the community take up anti-discrimination policies, it sends a clear message to the whole community that discrimination (eg homophobia, racism) will not be tolerated. This will encourage individuals to intervene, rather than tolerating or ignoring unacceptable behaviour.
- Increasing community acceptance of diversity is important in lessening community tolerance of violence based on discrimination. School and community workshops that involve extended families and raise awareness in both children and adults that it's okay to be different could be based on material already developed by other groups (eg workshops for people attracted to members of the same sex have been developed by Family Planning organisations around the country). Information to support such workshops may also be available from AIDS Councils, Sexual Health Units, Anti-Discrimination Units and the department of health in your state/territory.

SET UP SUPPORT GROUPS

- No matter how aware the community is, there will always be people who have been traumatised by violence or who feel vulnerable to harassment or assault. Support groups can be a useful forum for these people. Being able to discuss problems in a supportive environment, without having to worry about it being spread as gossip (especially in smaller communities), can be a valuable part of the healing process and can also enhance community safety.
- Meetings of support groups can be advertised on local community notice boards and/or in local places (takeaway shops, supermarket notice boards, the clinic, doctor's surgery). Include a phone contact in the advertising and advise people that it is okay to bring a support person. You may wish to ask people attending to make a small donation towards refreshments.
- The support group may run as a series of workshops or seminars that go for a couple of hours a week over an eight week period. After this time, the group may want to continue meeting in its own way. You may need to find ways of supporting people from meeting to meeting, either through peer support with other members of the group, or by giving them a phone contact to assist them through crises as they occur.

DESIGNATE SAFE SPACES

- 'Safe spaces' shouldn't just be the local refuge or shelter. People who are targets of harassment or violence should have places where they can go to feel safe, that aren't labelled. Examples of safe spaces in the community might be the school library, a coffee shop or milk bar, or the skate ramp. There might also be designated safe houses where children know they can find shelter and safety if they are being threatened.
- In remote areas, safe spaces may be at outstations, with extended family members who do not drink, or even at places like the women's centre or community kitchen or child care group. You can talk to people at outstations about making their outstations safe places, and what would need to be negotiated for this to occur. There are also accommodation services where a room can be rented for the night if required.
- Designating a place as a safe space may have legal requirements and can have legal consequences if things go wrong. If in doubt, contact a lawyer.

What are some structural changes that might help?

HAVE A COMMUNITY CENTRE

- A designated community centre can play an important role in bringing the community together. It can be used for social functions, community meetings and workshops, support groups, mediation sessions, and family violence healing sessions, just to name a few. A community centre can also be used as a focus for sporting and social activities for young people, to help relieve boredom and provide an alternative to drug and alcohol use.

MAKE PUBLIC PLACES SAFER

- Improving safety on the street and in public places such as hotels and clubs can help to reduce the impact of violence. Communities have addressed this issue in various ways, including:
 - enforcing the law by not serving people who are intoxicated with alcohol
 - assisting licensed premises to make their venues safer for their customers, particularly women and children
 - police and volunteer approaches to improving safety on the streets, through safety and security patrols, controls on consuming alcohol in public places, and services to provide immediate support and assistance to people in distress or need.

MAKE THE COMMUNITY SAFER BY DESIGN

- There is increasing interest in making communities safer by designing a physical environment that reduces opportunities for crimes to occur. This includes obvious physical deterrents to crime, such as locks, lighting and alarms, as well as Neighbourhood Watch and other community surveillance programs. It also includes making good use of public spaces to help discourage crime. For example, a basketball court in a public park or community centre will provide recreation for young people. Any activity that gets people out and working together – a clean-up day, a Neighbourhood Watch group, or a community meeting – can help to prevent crime.

SECTION 2 – WHAT CAN YOU DO?

Your role in working to make your community safer will depend on the community itself, but also your position within it. In order to help change the way things are, you need to understand the community. If you haven't been in the community very long but you're interested in initiating some changes that might make a difference, you could try out your ideas on a colleague who knows the community well, or other respected community members. Consult with as many people as you can – this will give you some idea of the level of support in the community for addressing violence. In order to make changes and sustain them, it's really important to involve the community in developing solutions, rather than trying to impose changes.

Remember that this sort of work can easily take over your life – working with the community is an important role but it's just one part of what you do. Try to keep things in perspective, and make sure that you have time for yourself and ways that you can be supported too. Chapter 3 discusses some ways that you can care for yourself.

So, what can you do to make your community safer? You can't do it on your own and it may take time to feel like you are making an impact on what is an overwhelming and complex issue. But there are some specific, practical steps you can take as an individual, as an organisation and as a community, to start the process. The workshop outlines below may be a starting point for positive action.

WORKSHOPS WITH OTHER HEALTH CARE WORKERS

- Talking about ways that the health service could provide information about violence (eg display board, posters).
- Discussing your role in finding out people or families that are considered to be 'at risk' of violence and adopting a monitoring role with them and perhaps members of other agencies (taking a case management role).
- Discuss finding out from local magistrates the nature of crimes that people have been imprisoned for in your local community.
- Discussing how sexual assault or violent crime has been dealt with before, and how the clinic was implicated, protected or able to be protected.
- Talking about how safe the health service feels and how it could be made to feel safer, and assessing how the safety of health care worker housing and community call-outs and after hours call processes could be improved (see Tool 5 for more information on risk assessment and management). If housing is provided by your employer, it is important to notify them if you think the accommodation is unsafe or not secure.
- Discussing ways to encourage feedback from clients.
- Identifying people or groups in the community you could work with to raise community awareness about the need to create safe spaces and fight discrimination.

WORKSHOPS WITHIN THE HEALTH SERVICE

- Discussing the roles of managers and workers in working with others to make the community safer (ie to what degree will managers commit to changes within the health service and support staff in more widespread change within the community?).
- Developing policies and protocols that aim to make the health service safe for clients and staff (see Tool 4).
- Discussing how to 'practise what you preach', by encouraging a culture where discrimination is not tolerated and where violence within the workplace is discussed and reported.

WORKSHOPS WITHIN THE COMMUNITY

- Building local capacity – encouraging people to build their self esteem, and know the types of violence and what they can do to have it affect them less.
- Sharing knowledge and ideas about structural changes that might make your community safer (eg improving lighting, setting up a Neighbourhood Watch or Safety House program).
- Talking about ways to bring the community together (eg through a community centre, regular community meetings, sporting or social activities).
- Finding out from police about their response time to episodes of violence, as well as other details such as what would warrant a police intervention, when they would come and/or what types of expectations they would have of you in the clinic. Try to determine situations in which it would be difficult for them to attend, and what alternatives there are for assistance (eg the roads are flooded and the airstrip is too wet to land).
- Asking for community assistance in developing a referral network of other agencies and organisations both within the community and external to the community that can be used to deal with episodes of violence more effectively.
- Inviting other agencies to explain how they react to and manage violence, at a series of workshops or seminars held in public places. This will give other services exposure to the issues of that community, and allow community people to have input to decisions about how violence is managed.

SECTION 3 – PUTTING IT INTO PRACTICE

An Aboriginal health worker has been employed by the community health service for three years. In that time she has noticed that the rate of injuries from violence has increased and that more women and children are being affected. Workers at the health service have also started to feel under threat but are receiving little support from management.

The health workers decide to take their safety into their own hands. They put a lock on the door of the room with the phone and shift the storage cabinet into that room. They talk to their employer about the need for duress alarms and the possibility of being provided with mobile phones. In the meantime they try to make community visits together and sometimes take a dog along for protection.

The Aboriginal health worker would like to help the community to do something about the rising levels of violence. She talks to the local school teacher who gets the children to paint a banner which they display in the school window. The kids also make some posters to put up in the health service. The teacher helps the health worker to write a brochure about the importance of reporting violence, which includes a list of local contacts.

The health worker and the teacher talk to community members about setting up safe spaces for the children. The school library and a family home in the centre of the community are chosen. By now there is rising momentum to make changes in the community. The publican clears a storeroom at the pub where the children can play away from the adults. There is talk of a soccer team starting up after the wet season and some work has begun on fixing up the community hall. As the community acknowledges that violence is a problem, the management of the health service agree to make some changes to improve worker safety.

Part C – Orientation and structured activities

Introduction

WHAT IS IN THIS PART OF THE MANUAL?

This part of the manual aims to help you decide where to begin in minimising the impact of violence in your community. It includes a variety of approaches to using the manual and developing a program for managing episodes of violence. You can choose one or more of these approaches, alone or as part of overall training and evaluation in your organisation.

- *Section 1* outlines some ways that new and existing staff could be oriented to the manual. It includes a tool for self-assessing your confidence in managing episodes of violence and how this ability changes over time.
- *Section 2* outlines two approaches to developing an organisational response to managing violence – a whole of organisation approach, and an incremental approach.
- *Section 3* has case studies that can be used to demonstrate issues that will need the cooperation of both staff and management. It also has structured activities that can assist in assessing readiness, training needs and potential barriers.
- *Section 4* includes notes and considerations for people wanting to facilitate programs to manage violence – this includes information about community development approaches, professional development approaches and handling difficult questions and situations.
- *Section 5* provides assessment tools that could be used to assess:
 - your organisation’s readiness to manage episodes of violence
 - your organisation’s ability to address diversity as you plan and implement a program for managing episodes of violence
 - the values that influence staff members’ approach and style of work.

WHY SHOULD YOU READ THIS PART OF THE MANUAL?

How you use this manual depends on you, your organisation and your setting. There is a lot of information to go through, and in some ways it raises more questions than it answers. The manual is just a starting point, and how far you take it will be influenced by your time and energy as well as your circumstances.

As an organisation, you can decide which parts of the manual are most relevant and useful for you, and then choose ways that you can prepare for and manage the violence you are likely to encounter. You might want to start by just going through the checklists at the end of each chapter. You may want to work together through some of the scenarios in the tables at the end of each chapter, and discuss possible options and strategies that apply in your setting.

You may want to use the manual as a starting point for substantial changes in your organisation – for example, developing policy and procedures, adopting a risk management approach generally, and putting systems into place for minimising the impact of violence. And you may want to go beyond the health service, getting others in the community involved in activities to make violence less likely and to manage it better when it does happen.

The most important thing is to involve everyone in the organisation and work together as a team. Section 2 outlines a whole of organisation approach to change.

As an individual, you can use the manual to help you think about how you manage episodes of violence now and how you could be better prepared and better able to care for your clients and for yourself. To do this, you can use the checklists and scenario tables in Part A, and the tools in Part B. You can also use the tool in Section 1 below, to assess your confidence in managing various situations. If there are any areas that you are not clear about, or you feel you need more training or support, you could talk to your employer.

SOURCES

Sections 2 to 5 of this part of the manual are adapted from Mind Matters Team (2000) *Mind Matters A Mental Health Promotion Program for Secondary Schools*. Professional Development Resource Materials. Compiled by Sandra Gapper, Mind Matters Team. Peacock Publications, Norwood SA. Enquiries should be directed to: Australian Principals' Associations Professional Development Council (APAPDC).

Section 1 – Orientation to the manual

This manual cannot tell you how to manage each episode of violence. You will need to assess the situation and your responses will be influenced by a range of factors. But it can help you to be prepared, and that can make dealing with episodes of violence easier.

Reading the manual should be part of the orientation to the job when health care workers first arrive in the community, to help them understand more about the job, and be prepared to deal with situations they may not have faced before. Part A is useful reference material, and the checklists and scenario tables can be used to stimulate thinking and discussion. The tools in Part B can be discussed with more experienced staff members, particularly how they might be applied in your setting.

Health care workers who have worked in a remote community for a while can also benefit, by using the manual to think about the way things are being done and how they could be changed – for example, gathering information that is relevant to the local service and region, developing procedures for particular situations, and setting up support systems for clients and staff. The manual could also be used as refresher information (eg changes in referral systems, legislation) and as part of ongoing professional development (eg training courses, undertaking research and study).

Refresher sessions will probably be needed at least annually, and perhaps more often in high risk communities. They might include other community members.

It is important that managers allow time for staff members to read the manual, discuss important points, and work through the checklists and scenario tables.

SELF-ASSESSMENT SHEET

This sheet can be used by staff members before and after orientation to this manual, to self-assess confidence in managing episodes of violence. This or a similar tool could be used with new staff as part of their orientation, and then periodically to assess how their training and experience are improving their ability to manage episodes of violence.

Evaluation on this issue could also be included with existing evaluation processes. For example, the ability to cope with episodes of violence could be incorporated into an annual performance review or training needs assessment. Follow-up support/training will be required when individuals are less confident in particular areas.

Self-assessment sheet

Use the numbers 1 to 7 to describe your level of confidence about managing the following situations, where 1 means that you don't feel at all confident and 7 means that you feel as confident as possible.

How confident are you that you:

Could care for a client who has been repeatedly physically assaulted by a family member?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Could manage a situation where children in a family within the community are being routinely neglected?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Could care for a client with a mental illness and violent tendencies?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Have the means to protect yourself when threatened by an angry man after helping his abused family?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Have strategies to avoid burn out and maintain your resilience and well-being?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Can keep accurate and detailed case notes and explain your observations in court?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Know what to do if threatened or harassed by a fellow worker?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Could keep a situation with an angry client from escalating?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Section 2 – Approaches to managing episodes of violence

There are a number of strategies that can be used to improve a situation, by promoting a change within the organisation and within attitudes towards managing violence.

1 A WHOLE OF ORGANISATION APPROACH

Action planning is a useful way to develop ideas about how to change the current situation within an organisation. In this approach, staff members consider the issues together and comment on them as appropriate. This approach can also be used with members of the community, both formally and informally, and with external groups. The approach uses a small group, question-and-answer technique.

Activity: Improving the current situation

Ask people to feed this information back to you. You can collate the information for presentation at staff meetings, professional development sessions or strategic planning days.

What is (constraints)

What two major factors inhibit the development of a whole-of-organisation approach to episodes of violence in your organisation? _____

What should be (ideal)

What ideal situation would overcome these problems? _____

What can be (improvements)

What positive and reasonable methods could be used to move toward the ideal situation? _____

Facilitate the following discussion:

- Where are we now?
- Where do we want to go from here?
- What changes do we need to make to achieve this?
- What do we need to make these changes? (resources)
- Timeline: what do we wish to achieve
 - Immediately/short term?
 - Gradually /long term?

2 INCREMENTAL IMPROVEMENTS TO MANAGING EPISODES OF VIOLENCE

An approach that aims for gradual change over the long term can be used instead of, or together with, a whole of organisation approach. This manual can be used to assist in achieving incremental improvements in the area of managing episodes of violence. Key elements to the approach include:

- completing the three assessment sheets in Section 5
- placing all relevant information into a folder for easy reference
- developing a work plan over a period of time (eg three months) to access information and complete tasks that will assist in developing an organisational approach that can be sustained.

Incremental improvement can be achieved by individuals within an organisation working together and independently. A *small working group* can progress the ideas included in the manual and establish a *broader consultative group* that can refine or endorse material. Where possible, there should be management support for the approaches adopted by the working group.

Individual

- Undertake to complete activities in the checklists in the manual as an individual, ask for information from management about expectations and any areas that are not clear.
- Read some of the information that is compiled in the resource sections and get this for your library or staff rooms and waiting areas.
- Gain a thorough knowledge of violence at the local level in your community, and some of the ways in which situations have been handled well and not well. Reflect on your capacity to act in these circumstances.

Working group

- Write up or photocopy the checklists for action in the manual.
- Develop a work plan for implementation of various aspects of the manual.
- Allocate appropriate people to implement or complete tasks in the manual, review mechanisms to ensure tasks are completed within reasonable timeframes and discuss issues of policy and/or procedure.
- Highlight with staff easy to access information from the resource lists in the document.
- Place summary tables in prominent places throughout the clinic rooms.
- Note the activities and health service infrastructure necessary to implement the recommendations in the toolkits.
- Develop and refine appropriate referral agency lists and place near the phone.
- Develop a rapport with people working in these agencies and update names on list as necessary.
- Decide which aspects of the manual people need to be aware of at various times (eg orientation, refresher, professional development).

Section 3 – Case studies

These case studies can be used as they are or adapted to your situation. They can be used to initiate discussions about how to manage violence and also to assess the current capacity and training needs of your organisation in managing episodes of violence. Other locally relevant case studies could also be used for this exercise. You may want to review the relevant tools in Part B.

In small groups or as members of a team, read and discuss the following case studies and note down some of the answers to the questions in activity number one.

CASE STUDY 1

You work in a remote area health service on an island about 40 minutes flight from the mainland. You have lived there for eight months, and are close friends with other people in the organisation, other professionals both visiting and living on the Island. You also have other friends within the community. You all have concerns about a young girl who has come to your attention through the school teacher, as someone who has been coming to class with bruises. The teacher's concern is that the child has become increasingly disengaged with school and community life since her mother and father divorced. Her mother has left her in the care of the father, and is only seeing the girl at the weekends and school holidays. You do not know the girl well, though you see the father out and about in the community and have had a beer with him at the local pub. The girl is encouraged to come to see you at the clinic, where she discloses physical abuse. She breaks down and cries, saying that she is becoming frightened of him, and that he comes into her room at night, and 'just stands there.' After this disclosure she will not submit to a physical examination as she is frightened that he will find out.

Discuss and decide on the best approach to deal with this situation.

Activity 1

Ask: What are the main issues for the health care worker in this case study?

Who are the main players in this particular case?

What are other issues the health care worker has to bear in mind in this situation?

Activity 2

As individuals or as a team, complete these steps to help staff to understand how to manage this event.

- List the implications of action or non-action for each of the people in the case study.
- What would be a successful outcome for each of the people in this case study?
- Why or why not might this be achievable?

Activity 3

Complete the organisational assessment sheets in Section 5.

- Assessment sheet 1 – organisational preparedness
- Assessment sheet 2 – organisational/team values
- Assessment sheet 3 – diversity survey

Activity 4

From the information you gather from these two exercises make a decision about the approach to take.

Activity 5

Review the chapters and tools of the manual for extra information and support.

CASE STUDY 2

A workplace manager has recently taken over the position of health service manager. This person has a good rapport with staff, and will listen to their concerns and spend time with them. However, as the months go by, staff members begin to notice a change in the management of the organisation. Previously, staff members were able to review mail that came into the organisation. Now, the mail is only being seen by the Manager. Regular staff meetings are no longer held, the Manager calls meetings at very short notice and only to deal with particular issues. People are no longer able to travel, and are having professional development and holiday applications 'knocked back'. Access to the Manager to discuss issues of importance is increasingly difficult, and feelings of secretiveness, an 'inner and outer' circle between favoured and unfavoured workmates have eroded what was generally a happy place to work. At workshops, people are singled out for 'ridicule' about their input by the Manager, and the increased turnover of staff has become of primary concern to the Management Committee who feel they are unable to do anything about the situation. Staff want to join the Unions, and a memo is passed to staff saying that the health service is to remain a non-union place of employment. Raised voices, absenteeism and long periods of silence have become features of the workplace. Staff want to meet about it, and have to do this off site and after work hours.

Discuss and decide on the best approach to deal with this situation.

Activity 1

Ask: What are the main issues for the staff and manager in this case study?

Who are the main players in this particular case?

What are other considerations that staff members have to bear in mind in this situation?

Activity 2

As individuals or as a team, complete these steps to assist staff understand how to manage this event.

- List the implications of action or non-action for each of the key people in the case study.
- What would be a successful outcome for each of the key people in this case study?
- Why or why not might this be achievable?

Activity 3

Complete the organisational assessment sheets in Section 5.

- Assessment sheet 1 – organisational preparedness
- Assessment sheet 2 – organisational/team values
- Assessment sheet 3 – diversity survey

Activity 4

From the information you gather from these two exercises, make a decision about the approach to take.

Activity 5

Review the chapters and toolkits of the manual for extra information and support.

Section 4 – Using a facilitated process

Sometimes, it is easier to allocate a staff member or a community person to be a facilitator in helping to increase people's confidence in managing episodes of violence. The facilitator is responsible for developing an approach that is task-oriented and has certain agreed outcomes. Facilitators need to be able to work with and between groups of people, have well-developed communication skills, and be able to coordinate activities and program/project support. It is vital that facilitators be seen to uphold some of the following principles:

- stopping and preventing violence
- protecting survivors of violence
- encouraging equality in relationships
- respecting cultural diversity while not condoning violence.

Facilitators should also seek to develop associations with agencies that have these shared values. The outcomes and agreed actions of this association can be developed into an inter-agency framework, jointly developed into policies and protocols, or be contained in a Memorandum of Understanding. These are mechanisms for work between agencies.

The role of a facilitator may include:

- program development, inter-agency coordination and liaison and referrals to the organisation
- conducting an assessment of the organisation as the basis for an action plan
- establishing a data collection system and ways of monitoring and evaluating the progress and impact of managing violence in an organisational setting
- maintaining contact with other professionals to ensure they are aware of the implications of the approach and the impact of the approach to managing episodes of violence day-to-day
- identifying sources of funding for managing episodes of violence
- staff development and awareness of the approach, the impact this will have on them and any professional development needs they will have
- supporting staff undertaking related work and study/support in this area
- liaising closely with other workers to identify at-risk individuals or circumstances which perpetuate violence
- developing a working relationship with outreach services as appropriate or able.

Facilitators may undertake the following activities to assess their ability to progress a range of activities, strategies and programs to assist people in the organisation to manage episodes of violence.

Question	Yes	No																				
Responsibility for the program will be taken by: <ul style="list-style-type: none"> • The leader • The facilitator • The group members • Different individuals depending on the activity • A committee Other:	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>											<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>										
In a program it is essential to provide:																						
a)																						
b)																						
c)																						
d)																						
e)																						
The resources we most use to develop a program are:																						
a)																						
b)																						
c)																						
d)																						
e)																						
Look back over your answers and complete the following sentence. Use this exercise to insert all of the information from this activity to develop an overall statement about what you are developing. In planning this program we will:																						

Activity 2 – community development and involvement

It is also important for facilitators to note the framework in which planning can be developed to achieve results. For instance, a community development approach has several key steps that will give a project the maximum chance of success.

- *Identify key personnel:* it is crucial to identify key personnel and seek their support and involvement in a project.
- *Seek broader support:* not only key personnel, but members of the community and/or organisation will need to be involved as soon as the benefits of a project can be identified and marketed for stronger support.
- *Identify particular community issues that tie in with the agenda of managing episodes of violence:* for instance, a recent assault, or alcohol related accidents, a party that went 'wrong' or past sexual experiences. See if other organisations could be involved to assist in managing these issues and develop referral networks for the people involved.
- *Identify past successes:* learn from these, as well as approaches that were not successful.
- *Provide information:* clear, accurate information is vital – why is this project being undertaken, where it has previously succeeded, what the benefits will be, what approach will be taken, how community members will be involved.
- *Offer added value:* given the importance of acceptance as a feature of a project's success, going the 'extra mile' can be essential – demonstrate an appreciation of the life and needs of a community by offering help, attending key functions and seeking out information and resources wherever possible.
- *Be prepared for setbacks:* setbacks are an inevitable part of community development and community involvement, and they need to be seen as a testing process which a worker goes through – keep the long term in mind, maintain personal resolve and seek support from key personnel in the organisation.
- *Establish a local project reference group:* very early on in a project a local project reference group could be established in order to share responsibility, decision making and investment in the outcomes.
- *Facilitate local networks:* do not make assumptions that all people in a local community know each other (or trust each other!). Encourage links between people and identify opportunities for them to be of mutual assistance. Coordinate this to happen.
- *Seek publicity when appropriate:* positive publicity can be extremely beneficial. Communities appreciate publicity about their positive achievements, especially if it is a community used to predominantly bad press about all of its 'problems'.
- *Celebrate achievements:* given that many community development projects take place in lower-economic areas it is essential to celebrate successes and achievements. If media links can be used to promote these positives, your work will become increasingly valuable.

Various strategies can be identified which can assist a community development approach to the issues involved with developing strategies to manage episodes of violence:

- Focus on community interests and avoid confrontations on positions.
- Identify what represents 'added-value' for people on staff and in the community.
- Provide information promptly and reliably, especially on available resources – your access to knowledge on service systems can be a vital asset.
- Assist with the development of strategic thinking and planning – develop a planning document for the project and use this for widespread consultation.

Questions that can get you thinking:

1. Who are key personnel to develop, implement and sustain this approach?

Staff _____

Other organisations _____

Community members _____

2. Are there networks or meetings that already occur that I could present my information to? If so,

What are they? _____

Who are involved? _____

3. How do I give people information about what I am doing so it is accessible and adds value to local initiatives?

Activity 3 – guidelines for running workshops

The following are key elements of running workshops.

Engage and acknowledge participants

Welcome participants, thank them for coming and make them feel comfortable by letting them know what's going to happen, inform them of any housekeeping details.

Establish credibility

Introduce yourself and what you do. Establish your credentials as the facilitator/ leader/speaker. Even if someone else introduces you, add something of your own.

Create safe spaces

Talking about violence is often a difficult and sensitive issue. You need to consider the space, the room and what you will have in place if people disclose personal information. As trainers we often ask people to participate and share their opinions, feelings and thoughts with others. Building relationships and trust with commitment to ensure confidentiality is of utmost importance. Try to develop clear expectations and/or agreements with people in relation to confidentiality at the beginning of the workshop.

Agreements may be proposed by any member of the group, and all group members are asked to indicate agreement and adherence to it. Agreements about confidentiality are important so that participants and facilitators can share freely and be certain what they say of a personal nature will not be repeated outside of the group.

Creating safe spaces and having agreements in place safeguarding people's confidentiality can be characterised by:

- voluntary participation in tasks
- commitment to group processes
- respect for other's point of views
- equitable air-time
- using 'I' statements to represent a point of view, feelings and experiences.

Get everyone talking

- 'Ice breakers' – although some people see them as time wasters, they are very useful to get participants talking, moving, and interacting, and assisting people to feel committed to group cohesion.
- Guided discussion sessions – it is also important to ensure everyone has a chance to participate. Strategies to involve people in discussions are important to keep things moving along.

Remember to thank people for their participation and contributions.

Identify expected outcomes

These are important for evaluation and crucial to the ultimate success of any training program. Present the desired outcomes for the program and negotiate participant's outcomes as appropriate. This helps to ensure ownership and a sense of control on the part of the participants. Outcomes assist you to more closely meet participants' needs and to state clearly what the program can and can't do.

Identify purpose, beliefs and assumptions

- Establish and negotiate the purpose of the workshop clearly.
- Establish a set of common principles that will guide the activity.
- Be aware of participants' beliefs or values in relation to a particular topic or the content of the training area.
- Check out assumptions that you have about your audience or what they are expecting, what information they need and what skills or knowledge level they already have.

Outline the process

- Explain how the day, session or activity is planned and what is expected of participants. Give them choices about participating, invite them to set themselves challenges to meet and take risks.
- Invite responses, questions and comments.
- Ask questions to ascertain comfort, usefulness etc.
- Be flexible, renegotiate or change direction as necessary.

Have you got what it takes?

- Commitment.
- Familiarity with this manual and the interactive process it embodies.
- Willingness to be flexible and do whatever is necessary.
- Ability to critically self reflect.
- Standards of excellence.
- Capacity to change.
- Entrepreneurial spirit – risk taker.
- Sense of humour...

Review these notes before starting any training session, together with aspects of this manual. Violence is a sensitive issue and perhaps people in the group have experienced or perpetuated the violence. There may be opportunities for people to work through these issues, and getting it right from the start will set the scene for people to have a good experience of your work.

The next set of notes considers professional development methods to use and how to handle difficult questions and situations.

INFORMATION SHEET – DECIDING ON THE PROFESSIONAL DEVELOPMENT METHOD TO USE

When you want to present knowledge:

- Group discussions
- Group or individual tasks
- Questions and answers
- Lectures/presentations with handouts and overheads
- Modelling a range of interactive strategies from this manual
- Notes and readings/articles
- Forums and panel discussions
- Multimedia presentations – films, videos, interactive computer programs

When you want to develop skills:

- Demonstrations
- Role play
- Peer teaching
- Instruction
- Modelling, observation and practice
- Reconstruction

Solve problems and actively involve people by using the following:

- Case studies
- Brainstorming
- Discussion groups
- Group and individual tasks and exercises
- Role play
- Questions

Changing behaviour and attitudes through:

- Presentations of testimonials and experiences
- Debates re: real values, issues and hypothetical situations
- Role play
- Group discussion
- Individual reading, and thinking
- Justification of positions and opinions
- Case studies
- Displays and campaigns.

INFORMATION SHEET – HANDLING DIFFICULT QUESTIONS AND SITUATIONS

Questions from participants

- Invite and encourage questions.
- It's okay not to know the answer.
- Invite others to answer the question.
- If someone is taking a long time to put their question or to get their point across try: *'I'm not sure of the point that you are trying to make – can you tell me the main point of your question?'* (answer, comment)?

Dealing with difficult questions

- Change your position – CENTRE.
- Acknowledge the question.
- Use active listening.
- Deal with the emotion.
- Ask questions *'Can you tell me more...?'*
- Include everyone else *'Did everyone hear the question?'*
- Find out more – why/what? *'What are some things...?/ Give me an example...'*
- Check out with others *'Who else is feeling like this?'*
- Identify needs and fears/blocks and barriers.
- Maintain your integrity and theirs.

When others are raising difficulties and fears

- Go with it.
- Say *'Yes, and...'*
- Avoid defensiveness.
- Build on, value and acknowledge.

Sample statements and responses

Statement	Responses
"It can't be done!"	'What would it need...?' 'What would it take...?' 'Is there a way...?'
"I'm not interested."	'What would interest you?'
"It's been done before and it didn't work."	'Tell me about it...' 'What would it take to make it work?'
"There's no money/no time!"	'What can we do?' 'What are the costs of not doing it?' 'What time/money do we have?'

Section 5 – Assessment sheets

ASSESSMENT SHEET 1: ORGANISATIONAL PREPAREDNESS

This activity is designed to assist the organisation and/or team think through its readiness to plan for and manage episodes of violence. As a result of undertaking this assessment, you should be able to assess your capacity to do this work.

Assessment	Yes	No
The organisation has a clearly articulated statement about violence		
The organisation's philosophy is consistent with its approach to violence		
The program being developed is based on a sound theoretical and conceptual foundation		
There is an evidence base for the approach being taken		
The organisation has experience in:		
• Community development		
• Working on violence issues		
• Collaboration with other community organisations		
The staff allocated to do the work have:		
• sound knowledge of violence issues		
• skills in working with people		
The senior levels of the organisation (eg Board, CEO) are supportive of the program		
The infrastructure of the organisation will support the program		
The program has a detailed budget allocation		
There will be regular supervision, briefing and debriefing for staff involved in the work		
There is a broader reference group that will provide support and critical analysis to the staff		
There is a clearly articulated goal, objective and outcome statement for the program		
An evaluation strategy for the program has been developed		
Team members have worked through their approach, style and techniques		
Potentially difficult situations have been discussed and planned for (eg disclosure)		

Look back over your responses. What do they tell you about your organisation's capacity to undertake a project to manage episodes of violence? Discuss and record the responses of people involved in the discussion. Make recommendations about the best way to go forward.

What does our organisation/team need to do in order to more adequately prepare?

Recommendations: Staff _____

ASSESSMENT SHEET 2 – ORGANISATIONAL AND/OR TEAM VALUES

This activity, which is designed to assist the organisation to think about the values that influence your approach and style of work, can be undertaken individually or as a team exercise. The activity is organised into two parts. The first part asks each individual to rank a list of values in priority order, according to their relevance to violence programs.

Rank the following values from 1 to 24, highest to lowest.

If some of the values you hold are not listed, please add them to the list.

Freedom	Justice	Honesty	Individuality
Family	Integrity	Responsibility	Cooperation
Empowerment	Communication	Relationships	Equality
Trust	Respect	Tolerance	Collaboration
Kinship	Diversity	Support	Resilience
Commitment	Advocacy	Identity	Autonomy

Now take the top five values that you believe should underpin your organisation's response to managing episodes of violence and write each one into a sentence:

When all members of your team have completed their list of five values, collate the responses, then:

- identify those most selected
- allow time for discussion and interpretation
- have the group draft statements about organisational/team goals, using the values identified
- explore and list ways in which those values are expressed in your programs
- discuss changes that may be needed and how to implement them appropriately.

ASSESSMENT SHEET 3 – DIVERSITY SURVEY

Complete your interpretation of the ability of the organisation to adapt and be cognisant of the following issues around diversity. There are many expressions of diversity related to gender, sexuality, race and identity.

1 – strongly disagree | 2 – disagree | 3 – neither agree nor disagree | 4 – agree | 5 – strongly agree

The organisation has acceptance of diversity as a part of its mission statement

1 2 3 4 5

The mission statement is accepted and understood by all

1 2 3 4 5

The organisational culture supports diversity

1 2 3 4 5

Staff members consider the values and needs of others

1 2 3 4 5

Staff support and manage each other

1 2 3 4 5

The Board/Committee is committed to diversity

1 2 3 4 5

Our organisation encourages and supports expressions of diversity

1 2 3 4 5

Our organisation values the talents and skills of each individual

1 2 3 4 5

Staff can feel secure in knowing their diversity is acknowledged and valued

1 2 3 4 5

Staff can count on each other irrespective of their diverse backgrounds

1 2 3 4 5

Our organisation is open to differences of opinion and perspective

1 2 3 4 5

Our organisation uses its diverse base creatively

1 2 3 4 5

Consider your responses. In what ways does the organisation address diversity in planning and implementing the management of episodes of violence? How can this be redressed? Brainstorm and document some ideas and how these might be recognised and implemented within the organisation.