

**Report on a review of literature on the epidemiology of
violence in rural and remote Australia and resources to the
management of violence**

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EXECUTIVE SUMMARY

Context

The Health Advisory Committee (HAC) of the National Health and Medical Research Council (NHMRC) commissioned this review of literature and resources as part of its advisory program to address the health needs of people in rural/remote Australia, one of the HAC's six health priorities.

The purpose of the literature review, and the identification and appraisal of related resources, is to inform the development of an evidence-based manual to assist health care workers in the management of incidents of violence in rural and remote Australia.

Approach

The definition of violence used as a basis of the search was: “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.” (World Health Organization)

A broad and inclusive search strategy (Appendix 1) was used and a large number of databases were searched for publications since 1980 using the terms **rural violence**, **rural homicide** and **rural suicide**. A number of unpublished conference papers were also obtained from the Australian Institute of Criminology (AIC).

The search identified 104 relevant articles, each of which is summarised in the annotated bibliography. Another 99 were excluded, the majority because they referred to rural violence in countries other than Australia or because they did not refer to either violence or to rural or remote Australia.

Findings

The types, prevalence and severity of violence in rural and remote Australia

The general violence statistics suggest that there are not large differences between the types, prevalence and severity of violence in metropolitan and non-metropolitan areas. However, where data exist for urban, other urban and rural or remote areas they suggest greater differences.

In relation to violence in rural and remote Australia overall, the literature suggests that:

- domestic/family violence in all its forms accounts for by far the greatest proportion of violence in rural and remote Australia;
- there are higher rates of domestic/family violence in rural and remote Australia than in other areas, particularly in Indigenous communities.

- women in rural and remote Australia experience domestic violence at greater rates than men;
- firearms related violence is more of an issue in rural and remote areas;
- there has been a marked increase in suicide among young males in rural areas across Australia over the last two decades;
- there is evidence of increasing rates of suicide in traditionally-oriented Indigenous communities; and
- there are high rates of violence towards health workers in rural and remote areas.

The management of violence and related resources

The limited material relating to barriers to effective management of violence by health workers 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 are also recommended, as is the maintenance of current information about services and legal issues.

While there is a range of resource and education kits on the management of violence for health workers, the majority of the material deals with domestic violence and potential violence from clients. There is little material on other forms of violence and few reports of evaluations of the effectiveness of kits.

There are a number of websites potentially of use to health workers which provide information on forms of violence, references, links to other sources and service or support contact details.

Gaps

There is an absence of robust measurement of the incidence and prevalence of violence in rural and remote Australia as the currently available data are both limited and patchy. There are indications that the relevant data may have been collected, possibly by ABS and AIHW, but is not in accessible form.

There are a number of gaps in the literature. In particular:

- little is known about the prevalence of or trends in different forms of domestic/family violence in rural and remote Australia;
- the currently available data on violence towards the aged are limited and patchy;
- there has been little research on the relationship between being a victim of/exposed to person to person violence and self harm/suicide;
- there is a lack of substantial evidence on violence towards health workers; and
- more research is needed on course content and approaches to providing appropriate education and professional support for rural and remote health workers.

1. INTRODUCTION

More than one quarter of all Australia's population (men, women and children) live in rural and remote areas.

The Health Advisory Committee (HAC) of the National Health and Medical Research Council (NHMRC) commissioned this review of literature and resources as part of its advisory program to address the health needs of people in rural/remote Australia, one of the HAC's six health priorities.

This report identifies and discusses the literature on the prevalence and severity of and trends in violence in rural and remote Australia according to population subgroups and types of violence. Literature relating to the management of violence by health workers in rural and remote Australia and resources available to assist health workers is also identified and discussed.

2. AIM

The aim of the literature review, and the identification and appraisal of related resources, is to inform the development of an evidence-based manual to assist health workers in the management of incidents of violence in rural and remote Australia.

3. METHOD

We used a broad and inclusive search strategy (set out in detail in Appendix 1) to address the possibility that there would not be much material available on violence in rural and remote Australia. A large number of databases were searched for publications since 1980 using the terms **rural violence**, **rural homicide** and **rural suicide**.

The World Health Organisation definition of violence was adopted: "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."

We consulted the Australian Bureau of Statistics (ABS) and Australian Institute of Criminology (AIC), and obtained a number of AIC papers presented at recent conferences and not yet available through databases.

3.1 Assessment approach

Following location of articles, publications and websites, each was initially reviewed to establish relevance. A number of publications were excluded from the review at this point either because they related to countries other than Australia or because they did not refer to either violence or to rural and remote Australia (Criterion 1). The papers were further reviewed to establish the issues addressed and categorised accordingly. Papers

which did not address any of the relevant issues were excluded on the basis of one of the criteria below.

Exclusion criteria
1. Paper does not address violence in rural and remote Australia, such as articles related to other countries (ie incorrectly indexed in bibliographies).
2. The data presented have been overtaken by those published in more recent studies.
3. The paper addresses material at a superficial level.
4. The same study is reported in more than one paper.
5. Findings are not generalisable because study undertaken in unique environment.

The following table identifies the number of papers excluded on the basis of each criterion.

<i>Criterion</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
Number of papers excluded	62*	3	29	3	2

*27 not rural; 27 not on violence; 8 not on Australia

The search identified 203 articles. As indicated in the table, 99 were excluded on the bases identified and 104 are summarised in the annotated bibliography.

4. RESULTS AND DISCUSSION

4.1 Person to person violence

There is a very substantial literature on person to person violence in rural and remote Australia. After review we identified 25 articles that present substantive material on the type, severity, prevalence or trends in person to person violence. Many other articles focus on responses to violence, and we discuss the component of the literature dealing with barriers to effective responses/management by health workers later.

To assist consideration of the literature we have grouped the material as shown in the following table. There are of course some overlaps between categories, particularly between the material in the domestically based and Indigenous categories.

Significant papers on person to person violence in rural/remote communities

	<i>General</i>	<i>Involving firearms</i>	<i>Domestic/family</i>	<i>Indigenous</i>	<i>Against health workers</i>
Type	Cuthbert et al 1993 Moller 1994 ABS 4509 1997 Mouzos 2000		Ferrante et al 1996	Mukherjee et al 1998 ATSIWTFV 1999 Blagg 2000 Memmott et al 2001 Mouzos 2001	Fisher et al 1995 Fisher et al 1996 Tolhurst et al 1999 Mayhew & Chappell 2001
Prevalence	Moller 1994 Cuthbert Hogg & Carrington 1996 ABS 4509 1997 James & Carcach 1997 Williams 1999 Mouzos 2000 Williams 2000	Mukherjee & Carcach 1996 ABS 4397 1997	Cook & Griffiths 1994 Ferrante et al 1996 Queensland Health 1999 Queensland Health 2000 Walk away, cool down 2001	Mukherjee et al 1998 Blagg 1999 Blagg 2000 Memmott et al 2001 Mouzos 2001	Fisher et al 1995 Fisher et al 1996
Severity	Cuthbert et al 1993			ATSIWTFV 1999 Memmott et al 2001	Fisher et al 1995 Fisher et al 1996
Trends	James & Carcach 1997 Williams 1999 Mouzos 2000 Williams 2000	Mukherjee & Carcach 1996		Memmott et al 2001 Mouzos 2001	

4.1.1 General aspects of violence in rural and remote areas

Papers on general aspects of violence in rural and remote areas are predominantly published by either the Australian Bureau of Statistics, the Australian Institute of Criminology or the Australian Institute of Health and Welfare. While these organisations produce many potentially relevant publications on violence, examination reveals very little material presented on an urban/rural basis as distinct from a jurisdictional basis. However, the structure of the data sets underlying the publications suggests that the organisations may be able to draw out material on an urban/rural basis if commissioned to do so.

At a very high level ABS 4509 presents estimates of assaults and sexual assaults in the 12 months up to April 1998 by metropolitan (ie capital city) and non-metropolitan areas. For assaults it shows that the victimisation prevalence rate in metropolitan areas was 4.2% compared with 4.4% in non-metropolitan areas, with a national rate of 4.3%. For female victims of sexual assault the victimisation prevalence rate in metropolitan areas was 0.5% compared with 0.4% in non-metropolitan areas, with a national rate of 0.4%.

Data on homicide disaggregated on an urban/rural basis shows little difference between urban and rural areas. James and Carcach 1997 report that “the urban/rural population distribution closely resembles the urban/rural homicide distribution, with 86 per cent of all homicide incidents between 1989 and 1996 occurring in urban areas and 14 per cent occurring in rural areas” (James and Carcach 1997:7). Similarly, Mouzos 2000 finds that “there was no significant difference between the geographical distribution of the Australian population and the geographical distribution of homicide incidents” during the period 1989 to 1999 (Mouzos 2000:21).

However, Moller 1994 reports death rates from interpersonal violence as being fairly constant across urban and rural areas, but rising sharply in remote areas to rates three and a half to five times as high as other areas (Moller 1994:3).

Both James and Carcach 1997 and Mouzos 2000 report that the rate of homicide across Australia has been remarkably stable over time.

Williams 1999 and Williams 2000 report on the effects of alcohol on social disorder related to rural youth using data drawn from the National Drug Strategy Household Survey. Although the Survey is professionally conducted and rigorous, substantial variation in estimates of the rates of some behaviours between the 1993, 1995 and 1998 surveys suggest that exogenous factors may be affecting the self-reporting response of some respondents. For example, the rate of hazardous or harmful use of alcohol among rural people aged 20 to 24 is reported to have risen from 30.9% in 1993 to 72.3% in 1995, but then to have fallen to 61.4% in 1998. However, the underlying pattern of relative rates of events reported below seems to have been broadly consistent over time.

Williams 1999 focuses on victims of alcohol-related social disorder and finds that despite substantial increases in the rate of alcohol consumption generally and hazardous or

harmful use in particular between 1993 and 1998, the rates of alcohol related personal and property disorder declined. In 1998, 31.7% of rural people of all ages suffered alcohol related personal abuse (verbal abuse, physical abuse, “put in fear”), compared with 44.5% five years earlier. The decline in the rate for young people was more marked: down from 56.6% to 33.1% for 14 to 19 year olds, 90.2% to 61.5% for 20 to 24 year olds, and 37.2% to 28.7% for persons aged 25 or over (Williams 1999:3).

These rates need to be seen in the context of increases in the rate of hazardous or harmful use of alcohol increasing from 16.3% across all rural age groups in 1993 to 38.8% in 1998, with rates in younger age groups of 68.6% for 14 to 19 year olds and 61.4% for 20 to 24 year olds (Williams 1999:2).

The 1998 rates of personal abuse and the pattern of decline since 1993 are broadly similar for metropolitan areas, although the 1998 rate among 14 to 19 year olds in metropolitan areas of 44.5% is considerably higher than the rural rate of 33.1%.

In relation to property disorder (theft and damage) 9.9% of rural people of all ages suffered from alcohol-related property disorder in 1998, down from 19.7% in 1993. This decline is mirrored in metropolitan areas. Rural people aged 14 to 19 and 20 to 24 suffered at a higher rate (14.3% and 13.9% respectively) than the rest of the population (8.9%).

Williams 2000 focuses on persons committing alcohol-related disorders and reports that the proportion of rural people of all ages verbally abusing somebody while affected by alcohol increased from 7.6% to 9.6% between 1993 and 1998, while the proportion physically abusing somebody fell from 3.3% to 1.6%. While rates of verbal abuse for younger people were much higher than the rest of the population (16.7% for 14 to 19 year olds and 33.4% for 20 to 24 year olds compared with 6.5% for others), the rates of physical abuse were not as different (1.7% for 14 to 19 year olds and 3.4% for 20 to 24 year olds compared with 1.5% for others). The pattern and trends in rural areas is broadly the same as in metropolitan areas (Williams 2000:2-3).

In relation to damage and theft of property, 3.1% of rural people of all ages damaged property while affected by alcohol in 1998 compared with 2.8% in 1993. Rates among young people were over 10%. 1.3% of rural young people stole property while affected by alcohol in 1998 compared with 1.8% in 1993. While the 1998 rate among people aged 20 to 24 was substantially higher than the population as a whole at 8.5%, the rate among people aged 14 to 19 was only 2.5%.

Hogg and Carrington 1996 report on a study of 447,093 crimes recorded in 1991-93 across five regions of New South Wales. They found rates of violent crime in some rural communities significantly higher than the State average, but noted that “there is also reason to believe that the relative incidence of hidden violence in rural communities is considerably higher than in urban centres so that the official data we have been relying on would tend to underestimate (possibly quite dramatically) the differential between urban and rural violence” (Hogg and Carrington 1998:163-164).

Cuthbert et al 1993 report on a study comparing characteristics of assault victims presenting at accident and emergency departments at St Vincent's Hospital in Darlinghurst with those presenting at the Albury, Wodonga and Wangaratta Hospitals. The study found 84% of females presenting at the rural hospitals knew their attackers, compared with only 49% of males, 47% of urban females and 19% of urban males.

4.1.2 Violence involving firearms

Another dimension of the literature deals with violence involving firearms.

Mukherjee and Carcach 1996 report on violent deaths caused by firearms on a regional basis in 1989 and 1994 using ABS data. In relation to homicides, they calculate a rate of 0.45 deaths per 100,000 population in capital cities in 1989, compared with a rate of 0.51 in the rest of Australia. In 1994, the rates are 0.44 and 0.51 respectively (Mukherjee and Caccach 1996:41). (While the authors do not report on the significance of this differential, given the very small numbers involved it is unlikely to be highly significant.)

Males across both years and in both metropolitan and other areas had higher rates than females (0.57 to 0.73 from males, as compared with 0.19 to 0.35 for females).

The ABS 1997 reports on firearms deaths over the period 1980 to 1995, during which the standardised firearms death rate across Australia fell from 4.9 per 100,000 population to 2.6. Through the 1990s homicide made up about 14% of the total deaths associated with firearms. On a geographic basis, death rates in capital cities fell from an average 3.0 per 100,000 in 1986-88 to 1.7 in 1995, death rates in other urban areas fell from 5.3 to 3.3 and death rates in rural areas fell from 8.2 to 4.9.

4.1.3 Domestic/family violence in rural and remote areas

While there is a large literature on responses to domestically based violence in rural and remote areas, there is very little literature on the type, severity, incidence and trends of such violence in rural areas. Ferrante et al 1996 begin a major study of the extent of domestic violence generally by quoting Matka 1991: "the short answer to the question 'How much domestic violence is there?' is that we don't know. There are no accurate figures on how widespread the problem may be in Australia" (Ferrante et al 1996:1).

Although Ferrante et al provide an excellent theoretical treatment of the issues and methods involved in measuring domestic violence and implement several of the methods, the paper provides only a limited analysis of rural domestic violence, based upon calls recorded in the Western Australian police Offence Information System in 1994.

This analysis shows a total domestic violence victimisation rate across the State of 100.8 per 100,000 adults. The rate in the Perth metropolitan area was 62.9, compared with a rate of 207.8 for non-metropolitan WA. The paper also presents an Indigenous:non-Indigenous comparison by area of residence. Using slightly different population estimates than the previous estimates, this comparison shows a total rate of 58.7 for non-

Indigenous persons, 55.9 in the metropolitan area and 66.6 outside, and a total rate of 2687.5 for Indigenous persons, 1935.3 in the metropolitan area and 2966.1 outside (Ferrante et al 1996:36-7).

The Queensland Health 1999 Women's Health Outcome Framework quotes data from the Women's Health Australia longitudinal study suggesting "an apparently significantly higher level of domestic and sexual violence in rural parts of Queensland compared to urban and remote areas in the State and rural areas [nationally]" (Queensland Health 1999:14).

Hogg and Carrington 1998 review the literature and conclude that "the limited available research on domestic violence in rural areas suggests that it is both common and heavily under-reported" (Hogg and Carrington 1998:164).

Several Queensland Health papers report on the evaluation of an initiative to combat the health impact of domestic violence against women. Central to the initiative was a program of universal routine screening for domestic violence in public sector health facilities. An evaluation of Stage 1 found 6.4% of 870 women attending a range of public hospital antenatal clinics, a primary care unit, an emergency department and a gynaecology outpatient clinic had experienced some form of domestic violence in the past year or had problems at home with someone who made them afraid for their safety. (Queensland Health Stage 1 2000:51).

The results from Stage 2 were broadly consistent with 7.0% of 2,858 women reporting affirmatively. While rates from non-metropolitan sites in Cairns (8.9%) and Nambour (10.7%) were higher than the average, so were rates from the Brisbane Mater's emergency department (8.5%) and the Royal Women's gynaecology outpatients clinic (12.4%) (Queensland Health Stage 2 Report:46). Of the 183 women reporting a form of violence in Stage 2, 82.5% reported emotional abuse, 45.9% reported physical abuse and 40.4% threatened abuse (Queensland Health Stage 2 Report:48).

Although these reports are interesting, the range of confounding variables applying means that the results can only be regarded as broadly indicative.

Cook and Griffiths 1994 report on a study of people experiencing domestic violence and presenting to services in Albany, Western Australia. During a five month study period data were collected by various support agencies on 253 people, 85% of whom were female. 17% of victims were Aboriginal. Types of violence experienced included physical (54%), verbal (51%), emotional (40%), threats (35%), against property (12%) and sexual (10%). Weapons were used in 6% of cases and their use was threatened in another 5%. In 43% of incidents there had been a previous history of violence, and 22% of clients had been in previous violent relationships (Cook and Griffiths 1994:6-8).

As the authors note, this kind of data collection suffers from a number of shortcomings, including only collecting information on people seeking assistance, relying upon busy agency staff to complete the form, relying upon people to be identified as suffering from

domestic violence when they presented for some other reason, and excluding some agencies which could not take part because of confidentiality concerns (Cook and Griffiths 1994:5).

A different approach is presented in the introduction to a description of the “Walk away, cool down” campaign to address domestic violence in far north Queensland. Data are reported on the rates of breaches of Domestic Violence Protection Orders indicating a breach rate in far north Queensland of 412 per 100,000, compared with between 80 and 85 in metropolitan Brisbane.

4.1.4 Violence involving Indigenous persons

While there is a substantial literature on violence associated with Indigenous persons, much of it deals with intervention and prevention strategies rather than type, severity, incidence and trends. Even where the material does deal with these issues, it tends to focus on Indigenous communities rather than Indigenous people living in rural and remote areas.

Mukherjee et al 1998 present the findings of the 1994 National Aboriginal and Torres Strait Islander Survey relating to law and justice issues. In relation to a question on whether family violence was a common problem in their local area, 45.1% of persons aged over 13 answered that it was, 23.5% that it was not, and 30.7% did not know. The authors note that a “did not know” response could be a way of avoiding answering a sensitive question. Broken down by area of State and gender, 27.7% of capital city males and 35.0% of capital city females believed family violence was a common problem, compared with 48.1% of males and 53.2% of females in other urban areas and 47.4% of males and 51.4% of females in rural areas (Mukherjee et al 1998:23-24).

A breakdown by State and area shows that across Australia 31.5% of Indigenous people in capital cities believed family violence to be a common problem, compared with 50.8% in other urban areas and a similar proportion in rural areas. (Note the figure quoted for rural areas is 36.2% but this is clearly an error, given that State by State figures for all States except Tasmania are over 45%.)

The paper also reports that 17% of Indigenous persons living in capital cities had been attacked or verbally threatened in the last year, compared with 12% living in other urban areas and 10% living in rural areas (Mukherjee et al 1998:26). Comparable figures for non-Indigenous persons are not available.

Mouzos 2001 presents a comparative analysis of Indigenous and non-Indigenous homicides from 1989 to 2000. The paper indicates that a significantly greater proportion of Indigenous homicides occurred in rural locations compared with non-Indigenous homicides (46.1% as against 15.9%) (Mouzos 2001:4).

The Aboriginal and Torres Strait Islander Women’s Task Force on Violence (ATSIWTFV) 1999 presents a range of data on the extent of violence towards Indigenous people without differentiating between urban and rural or remote areas. However, the

report does cite the 1988 Queensland Domestic Violence Task Force's estimate that domestic violence affects 90% of Indigenous families living in Deeds of Grant in Trust (reserve) communities, as well as other evidence that Indigenous victims of domestic assault were more likely to be seriously injured than non-Indigenous victims (ATSIWTFV 1999:96).

Blagg 1999 cites a wide range of papers examining the high rates of interpersonal violence in Indigenous communities, but does not identify any distinguishing rural and remote communities from others (Blagg 1999:10). Blagg 2000 cites data from the ABS survey reported in Mukherjee et al 1998 on perceptions of family violence as a problem between urban and rural areas. This paper also presents a typology of non-physical elements of family violence including social, verbal, sexual, economic and psychological (Blagg 2000:6).

Memmott et al 2001 is a major paper on violence in Indigenous communities and presents a literature review, information on the nature and distribution of various forms of violence, and describes a range of intervention programs. The literature review does not identify any sources presenting specific data on violence involving Indigenous people in rural and remote areas as distinct from Indigenous communities (Memmott et al 2001:8). The paper quotes Hatty 1987 as suggesting "that researchers should give up their preoccupation with studying the incidence of domestic violence as they will never be given the full picture, and they should rather concentrate on qualitative methods of inquiry".

Memmott et al 2001 propose a classification of violence including spouse assault, homicide, rape and sexual assault, child violence, suicide, self-injury, same sex, one-on-one altercations, inter-group violence, psychological violence, economic abuse, cyclic violence and dysfunctional community syndrome (Memmott et al 2001:36), and then reviews material on the incidence and characteristics of each.

4.1.5 Violence against health workers

There is a very sparse Australian literature on violence directed against health workers in rural and remote areas. The leading work is that carried out by Fisher et al 1995, presented in a journal article in Fisher et al 1996. In the literature review in Fisher et al 1996 the paper notes that "to the knowledge of this research group, no systematic attempt to gather data on the incidence of violence experienced by RANs [remote area nurses] and other remote health workers has occurred" (Fisher et al 1996:191).

The paper reports on the results of a questionnaire distributed to RANs through the Council of Remote Area Nurses of Australia and a teleconference interview with a small group of RANs.

Ninety-eight responses were received to the 237 questionnaires sent out – a response rate of 41.35%.

Of these a total of 61% lived in communities with a population of less than 1200, 25.5% were the only health worker in their community, and 82% were on call 24 hours a day. The types of violence experienced by the RANS in the previous 12 months included verbal aggression and obscene behaviour (82.1%), physical violence (48.1%), property damage (46.7%), sexual harassment (31.8%), telephone threats (17.0%), sexual abuse (10.6%) and stalking (8.3%) (Fisher et al 1996:192-193). Cross-tabulation of the results showed more violence took place in smaller communities, to nurses on-call, and to those working without access to a security escort.

As the paper notes, these results may not be generalisable to all RANs. CRANA membership tends to include RANs who intend to stay in remote positions for some time (the respondents were experienced in working in remote areas), and the response rate was low (Fisher et al 1996:197). However, the data shows that even if the non-responders experienced no violence, 20% of all remote RANs experienced physical violence and/or property damage. Similarly, these data indicate that even if the non-responders experienced no violence, 23% of all GPs surveyed experienced verbal abuse. The difference in the forms of violence experienced by RANs and GPs is striking.

Tolhurst et al 1999 examine safety issues around rural general practitioners (GPs) providing after hours medical care using focus groups and a questionnaire. A response rate of 51.8% was achieved to a questionnaire distributed to a total of 606 GPs in central west NSW, Gippsland Victoria and all of rural Western Australia. A response rate of 51.8% was achieved with a roughly 2:1 male:female ratio.

The types of violence experienced by respondents in the past 12 months included verbal abuse (45.5%), property damage or theft (24.2%), sexual harassment (8.6%), physical abuse (3.2%), stalking (2.5%) and sexual abuse (0.3%) (Tolhurst et al 1999). Respondents were also asked if during their rural medical career they had ever suffered stalking (24.2% had), physical abuse (20.1%), sexual harassment (23.2%) and sexual abuse (1.6%).

Sexual harassment was particularly common among female respondents, with 20% having experienced it over the past 12 months and 45% during their rural medical career. Overall, 73% of respondents reported some kind of violence during their rural medical careers.

Mayhew and Chappell 2001 present an overview of occupational violence in the health sector. They distinguish between external violence (such as armed hold-ups), client-initiated violence and internal violence (between employees within an organisation) and discuss factors affecting reporting and measurement of these types of violence. While reporting on international experience which may provide insights for the Australian sector, they note that “there has been little substantive occupational violence research in the Australian health care sector” (Mayhew and Chappell 2001:9) and conclude that “the incidence and severity of occupational violence in the Australian health care sector is poorly recognised, and there are no solid data available (14).

4.2 Suicide and self-harm

Significant papers on self harm and suicide in rural/remote communities

	<i>General</i>	<i>Youth</i>	<i>Migrant</i>	<i>Indigenous</i>
Type	Legislative Council 1994 Graham AL 1999 Officer et al 1999	Dudley et al 1998		Hunter 1991 Hunter et al 1999
Prevalence	Legislative Council 1994 Moller 1994 Graham AL 1999 Officer et al 1999	Halstead 1992 Graham D 1994 Legislative Council 1994 De Vaux 1996 Green 1996 Baume & Clinton 1997 Dudley et al 1998 Wyn et al 1998 Reynolds & Conroy 1999	Legislative Council 1994 Morrell et al 1999	Hunter 1991 Legislative Council 1994 Hunter et al 1999
Severity	Graham AL 1999			Hunter 1991 Hunter et al 1999
Trends	Legislative Council 1994 Graham AL 1999	Graham D 1994 Legislative Council 1994 De Vaux 1996 Baume & Clinton 1997 Dudley 1998		Legislative Council 1994 Hunter et al 1999

The literature on suicide and self-harm in rural and remote Australia is dominated by papers on suicide, particularly youth suicide.

Only Graham 1999 and Hunter 1991 discuss forms of self-harm other than suicide.

In relation to rural suicide generally, the Report of the NSW Legislative Council Standing Committee on Social Issues on Suicide in Rural New South Wales (Legislative Council Report 1995) summarises research up to 1995. The report refers to ABS data suggesting “that suicide rates for men of all ages and for women differ little between rural and urban locations. However, for young men in rural areas the suicide rate is considerably higher” (NSW Legislative Council 1994:30).

Moller 1994 report suicide rates among males were almost fifty per cent higher in other remote areas than the rest of the country, whereas female suicide rates fell from the highest rate in capital cities to the lowest rate in other remote areas (Moller 1994:3)

Turning to methods of suicide, the Report notes that firearms suicide rates for males in smaller rural areas have remained broadly constant from 1971 to 1991 at around 14 per 100,000, while rates in major rural areas have declined from 12.1 to 5.4 over the same time period. Hanging rates have increased over the same period for males in major rural areas from 2.2 to 7.2 per 100,000, while the rate for males in other rural areas has risen from 2.8 to 6.4 (NSW Legislative Council 1994:42-48).

Suicide by poisoning is the most common method among women in both rural and urban areas. Of other methods, gas inhalation among males in major rural areas increased from 2.2 to 6.5 per 100,000 population between 1971 and 1992, while the rate for males in other rural areas rose from 2.8 to 4.8 (NSW Legislative Council 1994:48-49).

Graham 1999 examines trends in suicide and self-inflicted injuries in Victoria from 1992 to 1998, and concludes that the hanging rate increased across all regions during the period. A decline in the firearms suicide rate resulted mainly from a decrease in the metropolitan rate (Graham 1999:14). The paper also finds that while 27% of suicides during the period took place in rural and remote areas, only 19% of incidents of self-inflicted non-fatal harm occurred in rural and remote areas.

Officer et al (5th NRHA Conference) presents cumulative data for firearms suicides in WA over the period 1986 to 1995, and finds that the crude rate in the Wheatbelt region (where firearms were more readily available) was 43 per 1,000,000 population compared with 14 in the metropolitan area. Baume and Clinton 1997 also suggest that the availability of firearms in rural areas may convert impulsive suicide attempts into deaths (Baume and Clinton 1997). De Vaux 1996 observes that “access to guns is also likely to contribute to the high rate of successful suicide. Over 50 per cent of suicides by rural males are by guns compared with 23 per cent among urban males” (De Vaux 1996:44).

The very considerable literature on rural youth suicide draws heavily on work by Dudley and his collaborators, including articles in 1992 and 1998 and various unpublished papers.

Wyn et al 1998 state that “there is disagreement over whether suicide rates for young people are higher than in urban areas” and cite data from Dudley et al 1992 showing that the rate of suicides for males aged 15-19 in NSW rural communities increased between 1964 and 1988 from 2.8 to 14.8 per 100,000. On the other hand, Cantor and Coorey 1993 found similar rates of suicide for young men in rural and urban areas in Queensland (Wyn et al 1998:16).

Dudley et al 1998 review changes in suicide rates across urban and rural areas in all States, and conclude that rates for 15 to 24 year old males increased substantially between 1964 and 1993, while the rate for females of a similar age did not change. There was a “disproportionate increase in suicide rates in young men in small rural areas... occurring consistently in all Australian States” (Dudley et al 1998).

The paper notes the findings of Cantor and Coorey, and observes that “our study confirms their observations for Queensland cities with populations of over 25,000, but notes a massive increase in towns with fewer than 4,000 people, with substantial numbers supporting this finding” (Dudley et al 1998).

The pattern reported by Dudley et al is consistent with:

- De Vaux 1996 citing ABS data showing 1992 suicide rates for 15 to 24 year old males across Australia of 24.7 per 100,000 for urban areas and 37.7 for rural areas, compared with rates for males of all ages of 20.0 for urban areas and 26.0 for rural areas (De Vaux 1996:44).
- Reynolds and Conroy 1999 present 1995 data showing suicide rates for rural male youths of 33.9 per 100,000 compared with 23.6 for young males in urban areas. The ratio of suicides of young males to suicides of young females was almost 4:1 (Reynolds and Conroy 1999).
- Evidence presented to the NSW Legislative Council and summarised in NSW Legislative Council 1994:33-41.

A notable gap in the literature is the absence of material dealing with suicide among the elderly population in rural areas. The NSW Legislative Council noted that it was unable to discern any overall trends (NSW Legislative Council 1994:32). De Vaux 1996 comments that “the increase in the suicide rate for young males should not overshadow the continuing high rates among other age groups”, but does not present any data specific to rural elderly.

Morell et al 1999 examine urban and rural suicide differentials in NSW for migrants and the Australian-born over the period 1985 to 1994. The paper concludes that while there are no significant differences in suicide risk between urban and rural Australian-born males (rates of 24.6 and 26.7 per 100,000 respectively), migrant males in rural areas are at significantly higher risk than those in urban areas (38.2 per 100,000 compared with 19.9). However, the overall risk for migrant males (21.3) is less than for the Australian-born (25.2) (Morell et al 1999)

There was no statistically significant difference in risk for migrant women between urban and rural areas, although overall rates in migrant women from some areas overseas were higher than for Australian-born women.

The work by Morell et al supersedes papers by Crowe 1994 and Burnley 1994 reported in Legislative Council Report 1995 (p50) concluding that there was little difference in suicide rates between people born in Australia and those born overseas.

In relation to suicide amongst Indigenous persons, Hunter et al 1999 includes a comprehensive review of overseas and Australian literature. It finds that “notwithstanding the frequency and saliency of discussions of Aboriginal suicide, there

have been few systematic research studies of the actual nature, extent and distribution of these behaviours across communities and time in a particular region”. It concludes that “it is now clear that the phenomenon of Indigenous suicide is moving rapidly through traditionally-oriented communities in the Northern Territory and appearing, intermittently, in other areas of Australia” (Hunter et al 1999:9).

Hunter et al 1999 presents an analysis of Indigenous suicide in north Queensland, noting that between 30 and 39% (depending on data source) of Indigenous suicides in Queensland in the period 1990 to 1996 took place in three communities in north Queensland, even though these made up only 5% of the total population of Aboriginal and Torres Strait Islander Queenslanders (p15).

Hunter 1991 presents evidence suggesting that in the Kimberley, self-destructive behaviours, including suicide, parasuicide and self-mutilation, were increasing among young Aboriginal adults (Hunter 1991:657).

4.3 Barriers to the effective management of violence by health workers

There are a number of papers which address issues related to the non-reporting of violence within rural and remote communities. It is arguable that this dimension of the subject is an element to be considered when addressing barriers to the management of violence by health workers, on the grounds that if the violence is not reported or help sought, health workers will be impeded in their management of it.

<i>Barriers to reporting child abuse</i>	<i>Barriers to using domestic violence services</i>
Manning & Cheers 1994	Samyia-Coorey 1987
	Coorey 1988
	Queensland Health 1999
	Schaffer 1999

Manning and Cheers 1994 conclude that there appear to be specific factors discouraging the reporting of child abuse in rural communities. These include a feeling that the community should be responsible for its members; lack of confidence in relevant authorities; preference for notifying a local professional, who often act as ‘gatekeepers’; and possibly a tendency to disbelieve abuse is occurring.

Samyia-Coorey 1987 identifies a number of reasons why victims of domestic violence cannot get access to services, the main reasons being lack of available services, lack of information about them and how to access them. Fear of lack of confidentiality and feelings of shame are also reported as reasons. The failure of communities to recognise domestic violence as a problem is considered to further alienate victims from services. Harsh climatic conditions and lack of access to transport from remote locations are also identified as barriers to obtaining assistance.

In 1988 Coorey added to this list of barriers: the fear of partners; concern they would not be able to support their children; limited money and other resources; limited knowledge of emergency support services and non-enforcement by police of legislation.

Queensland Health 1999 reports that women in rural and remote parts of the State appear to suffer higher rates of domestic violence but services which operate in urban areas are unsuitable for a range of reasons. The particular barriers to rural women seeking support are identified as including sexist and conservative social attitudes, geographic isolation, little knowledge of services and cultural dissonance relating to domestic violence and elder abuse for migrant women.

The paper notes that suitable strategies for providing support to rural women involve the use of new technologies, which requires access to reliable equipment and services and training in the skills required. They also note that rural service providers have a particular need for resources and personal support if they are to meet the needs of victims of violence.

Lack of awareness of relevant rights and services, low self-esteem, lack of stable support systems and suspicion of mainstream services are identified in the same paper as being particular impediments to young women seeking support.

Schaffer 1999, in a research project on older and isolated women experiencing domestic violence, confirmed that transport, conservative rural culture, reluctance of police to attend domestic disputes where numbers of weapons were known to be owned by perpetrators, lack of confidentiality, no access to family resources but ineligibility for income support, poverty, limited English and age-linked reversion to language of origin for migrant women as being significant inhibitors to older women removing themselves from violent domestic circumstances.

The following papers specifically address barriers to the effectiveness of health workers responding to violence in rural and remote communities.

The literature on the subject is slight. What there is identifies impediments to effectiveness arising from judgmental attitudes and stereotyping, cultural insensitivity, knowledge limitations regarding indicators of violence and self-harm, deficient communication skills, lack of confidence in relating to adolescents, absence of interagency networks, inadequate information about local resources, insufficient knowledge of legal provisions and lack of employer support.

Dowd and Johnson 1995 identify cultural and racial stereotyping, lack of appropriate knowledge and referrals, informal workplace arrangements (absence of protocols) and lack of employer support as important inhibitors to the effectiveness of health workers in rural and remote areas. They point particularly to the need for post-graduate education to adequately prepare nurses for remote area roles.

<i>Attitudes and knowledge of health workers</i>	<i>Educational programs for health workers</i>
Davies et al 1996	Anderson et al 1997
Bates & Brown 1998	Harris et al 1997
Bates et al 2001	McCosker et al 1999
Stevens et al 2001	

Davies et al 1996 undertook a study to examine barriers to the identification and assessment of and intervention in violence against women by rural community health workers.

While the sample of respondents over-represented nurses and under represented other groups, including GPs, social workers, ATSI health workers and allied health workers, and the method used means the findings are not generalisable (acknowledged by the authors), the findings are consistent with those of other studies. The key barriers to the assessment aspect of responding to victims of violence were identified as being not knowing how to respond to victims; unsure what was wanted of them; not knowing how to make an assessment; and having no protocols.

The key barriers to intervention were considered to be absence of a referral network; lack of support systems; lack of support options for victims; and inadequate resources for health promotion activities.

The paper also reports that some of the respondents undertook to 'mediate' between couples where violence was known to be occurring, an approach described by the authors as harmful.

Bates and Brown 1998 examine the knowledge of, attitudes to and management strategies for domestic violence among doctors and nurses in the accident and emergency departments of two metropolitan and two rural hospitals in the Hunter region of NSW.

While the study reports on the characteristics of the responders, there is no analysis of the possibility of bias between responders and non-responders.

However, the findings were that the vast majority (84%) of respondents considered they should be able to recognise domestic violence victims but only 38% considered they would be able to do so. The responses on management practices indicated a range of approaches to questioning and examining possible victims and a marked tendency not to provide referral information, on the basis that it was not their role, it was pointless or they thought the victim would not want it.

The paper concludes that staff recognise the importance of their role in managing victims of domestic violence but did not feel they had the skills to detect all victims or to deal effectively with the problem.

The authors consider that the study indicates a need for training in communication skills, particularly direct questioning techniques, and the recognition of risk factors. The development of policies and protocols related to accessing local resources and involving the police were also considered necessary. The authors consider these should be developed through establishing links between hospitals and community services and family support groups, as well as constant updating of information resources.

Finally, most respondents (92%) indicated they would be sympathetic to suspected victims but only 70% would be sympathetic if the victim returned after a further incident. The authors consider this indicates the need for knowledge about the dynamics of domestic violence and an understanding of service provider frustration and powerlessness when planning domestic violence training for service providers.

Bates et al 1998 sought to identify how health services (hospitals and community health centres) could improve the quality of care to victims of domestic violence by conducting focus groups with women who had experienced violence and utilised health services as a result. These participants were drawn from contact lists of refuges, presenting a potential for bias in the results recognised by the authors.

The data were collected via nine focus groups. Three were conducted in rural areas and two had only ATSI members.

The factors reported as influencing attendance included knowledge that the service could assist with domestic violence; the degree and type of injury suffered; long waits or delays in service.

The study resulted in the identification of six areas for improvement:

- improve services to Aboriginal women – increased understanding of culture and reduced stereotyping;
- increase access to services – including other agencies in networking and domestic violence training;
- promote available services – increased advertising of services, including culturally appropriate targeting to Aboriginal women;
- improve the health service environment – more private assessment/consultation areas;
- educate health service providers – regarding understanding of domestic violence and its effects and discrediting of myths; and
- provide specialist health services – in the form of designated positions or units and 24 hour services, support groups, counselling services and work with schools to assist children in violent situations.

Stevens et al 2001 report on the development, implementation and preliminary evaluation of a project to break down barriers between adolescents and GPs in rural South Australia sponsored by a collaboration between three divisions of general practice.

The implementation design consists of:

- Education sessions for service providers, in which divisions of general practice separately and jointly present sessions on such issues as youth depression and suicide and effective interaction with young people for GPs, allied health workers, school staff and community members.
- Follow-up visits to schools by GPs or the project officer at which the subjects discussed were identified by the students beforehand.
- Establishing a 'youth friendly' general practice through student visits to the local practice; endorsement of an appropriate consultation protocol (HEADSS); and plans to develop a Youth Friendly Practice Manual.

- Parent education sessions on issues faced by adolescents.
- Establishment of partnerships between GPs, schools and the community.
- Development of a resource package on such information as setting up networks, evaluation and management.

The project is still in implementation but preliminary evaluation has been conducted by an external evaluator. The relevant findings to date include that GP level of comfort in dealing with adolescents was increased and adolescents' awareness of GP roles and responsibilities also increased.

Important 'pre-conditions' to GP effectiveness are identified as being:

- interest in and commitment to adolescent health; and
- access to ongoing information and support.

The authors report that GP effectiveness is contributed to by shared interest and commitment from Divisions and schools, in the latter case, particularly through having a school counsellor able to link the student and the GP.

Anderson et al 1997, Harris et al 1997 and McCosker et al 1999 all report on the same project – the development of an education package for rural community health workers based on needs assessment and involvement of health workers in the planning phase.

All three papers are included because Anderson et al focus on the needs assessment phase, Harris et al on the education modules and evaluation and McCosker et al contribute additional material on the evaluation.

The first phase of the project sought to identify the educational needs of rural community health workers in the Wide Bay region of Queensland. The report indicates it was based on a random stratified sample of 52 community based health workers, but no further details of sample selection or response rate are provided.

Based on input from six focus groups, the study concludes that an appropriate education program should:

- address rural issues impacting on service delivery;
- incorporate strategies to improve networking opportunities;
- provide affective and cognitive skill development training; and
- be provided through a distance education program.

Harris et al 1997 add to the information provided by Anderson. They note that the literature review element of the study indicated that there appeared to be no extant education model for rural community-based health workers which incorporated effective approaches to intervention with women experiencing abuse, and that no community development framework existed to guide training initiatives on the subject for this group of health professionals. They also note that the literature emphasised the need to apply a community development framework, particularly in addressing training needs of health workers in rural settings.

Harris et al report that there were five focus group discussions with 28 community-based health workers and key informants from the region in which the program was to be implemented (which is at odds with the six groups and 52 participants reported by Anderson et al).

Harris et al outline in some detail a seven module training package developed on the basis of the focus group recommendations. It is reported that one of the key recommendations was that attendance requirements be minimized in the form of delivery of the package to be designed. This resulted in the development of a self-paced distance education package supported by teleconferences and a mentorship program. Sixty health workers from a wide range of disciplines are reported to have participated in the pilot implementation phase.

Evaluation of the initiative focussed on assessing the effectiveness of the package. Pre-course and post-course questionnaires requiring quantitative and qualitative responses on policies, attitude statements, violence indicators and service networks were the mechanisms for evaluating the program. Evaluative comments were also sought from participants at the end of each module. The conclusion was that the package was successful in assisting communities to work towards increased access to services, intervention and prevention of violence.

The authors conclude that the package's effectiveness is attributable to good needs assessment and involvement of the target group in the planning phase. They also note that for rural communities, effective educational strategies need to incorporate multidisciplinary training, intersectoral collaboration and networking.

McCosker et al 1999 report further on the same project and note that participants reported that the most useful elements of the course were its user-friendly format, practical content and real world examples. They conclude that participation in the education package increased participants' knowledge of networks; their own role in supporting victims of violence; relevant policies and legislation; dissemination of information and indicators of violence.

The paper reports that the findings of this study indicate a need for "a much larger study, which includes all professional groups of rural health workers, especially general practitioners who did not self-select for participation".

The subsequent effectiveness of program participants in actually responding to the victims of violence does not appear to have been evaluated.

While there are significant weaknesses in the methodology of several of the studies cited, as well as inadequacies in the reporting of some, the consistency of findings tends to suggest some store might be set by the results. However, further work clearly needs to be undertaken to clarify the violence-related educational needs of health workers and appropriate strategies, as well as other possible barriers to the effective management of violence.

4.4 Resources for health workers

4.4.1 Education kits and information packages

A number of references relating to resource/education kits on the management of violence for health workers have been sourced. The majority of these deal with domestic violence and potential violence from clients in rural and remote settings.

<i>Domestic violence</i>	<i>Child abuse</i>	<i>Indigenous violence</i>	<i>Client violence</i>
Woolley 1994	Collingridge 1997	AMA & Healthway 1998	DHHS (NIOSH) 1989
Woolley 1994	Elliot 1991		SchorNSTein 1997
Lodden-Mallee W's Health 1997	Kennedy 1991		Aust Institute of Criminology 2000
Wileman & Wileman 1997			Internat Council of Nurses 2001
Commonwealth OSW 1998			
Health Department of WA 1999			

Apart from the evaluation of the package developed and reported on by Harris et al in 1997, discussed in the previous section, little evaluative work is reported to have been undertaken on the information contained in, effectiveness or appropriateness of the kits.

Some of the kits cover the subject they address from a knowledge and management/skills development perspective (Elliot 1991, Health Department of WA 1999); some introduce protocols (SchorNSTein 1997, International Council of Nurses 2001); some focus on providing information on support services (Lodden-Mallee Women's Health 1997, Commonwealth Office of the Status of Women 1998); and others are introductory packages on indicators of and the impact of violence (Australian Institute of Criminology 2000, DVR Service (South West) 1998). Only Kennedy 1991 and Wileman & Wileman 1997 deal directly with possible responses to victims.

A small number of documents which list resources/services potentially of use to health workers addressing violence in rural and remote communities have also been identified. These include an outline of the violence-related financial and counselling services available nationwide from Centrelink (Centrelink 1998); emergency relief agencies in the Northern Territory and the types of services they provide; and information on contact points related to sexual assault services (Queensland Health 2001 and Territory Health Services 2001)

The coverage of the issues by these kits and listings is patchy, with the management of some forms of violence being addressed superficially or not at all and publications on contact points and some issues not having been sourced for some States.

4.4.2 Government and community strategies

While not strictly resources for use by health workers, the various strategies developed by governments and communities to prevent/reduce the incidence of violence provide an important context for the role of health workers in addressing violence. Collectively these strategies endorse the view that violence is unacceptable, provide information on the nature and causes of violence, seek to empower communities to address the problem and associated issues, and provide services and support for victims and those seeking to assist them.

To this extent such strategies are an important feature of the operational environment of health workers and can directly contribute to the information and support networks available to them. These strategies also frequently involve the development and/or provision of education programs for health workers. However, in Hamel 1999 it is noted that “programs ... could have ... benefits in reducing violence, although there is currently no evidence of any such effects.”

The material we have been able to source on government and community strategies is identified according to major subject matter in the following table.

Type of violence	Sector	General	Indigenous	Young people	Police/legal
Multiple		Queensland Health Stages 1 & 2 2000 Dept of Health Services Vic 2001 Hamel 1999	Miller 1992 Ellis 1996 Qld Dept of ATSI Policy & Develop't 2000 Burney 2001 NSW Health 2001	Stokes & Wyn 1998	
Domestic		Lovell 1996 Mugford & Nelson 1996 (2) La Nauze & Rutherford 1997 Weeks & Quinn 2000 Office W's Policy Vic 2001 Thiel 2001	Allbrook Cattalini 1992 Mugford & Nelson 1996 (1) Blagg 2000 Franks 2000 Smith & Williams Walk away, cool down 2000	Indermaur et al 1998 Blagg 1999 National Crime Prevention 1999	Knowles 1996 Law Reform Committee of Victoria 2000 McMahon et al
Women		Hastings & MacLean 1999 Commonwealth OSW 2001			
Sexual assault		Baxter 1992 Sloan		Makepeace et al 2001	

	Legislat Council of NSW 1996			
Child abuse	Tomison & Poole 2000	Harrison 1991 IINA 1996 SNAICC 1996		
Alcohol related	Queensland Health 2000	Flick 1996		

4.4.3 Websites

A number of websites have been identified, listed at Appendix 3, which provide information on violence and related services.

Some websites provide information about the form of violence, references and links to other sources of information plus contact details for support/services, while others provide contact information only. The key sites, largely because they provide core information and links to other sites, appear to be:

- http://www.wire.org.au/pages/default.cfn?page_id=1504 (Information for women on domestic violence and assault)
- http://www.aifs.org.au/nch/nch_menu.html (National Clearing House on Child Abuse)
- <http://www.acys.utas.edu.au/ncys/topics/viol.htm> (National Clearing House on Youth Studies)
- <http://home.vicnet.net.au/~chomp/contacts.html> (Youth suicide support)
- http://www.osha-stc.gov/SLTC/workplaceviolence/healthcare/healthcare_menu.html
- <http://www.nwjc.org.au/wlsn> (A national network of women's legal services)
- <http://www.nwjc.org.au/atisla.html> (National Women's Justice Coalition)
- <http://www.powerup.com.au/~atsils/index.html> (ATSI legal services, including outreach and family services)
- <http://www.nla.aust.net.au/html/main.html> (National Legal Aid network)
- <http://www.sjc.uq.edu.au/ozguide/crime.html>

4.4.4 Counselling and support networks

Three organisations provide relatively accessible counselling and support services appropriate to addressing issues related to violence in rural and remote Australia:

- CRANA (Council of Remote Area Nurses of Australia) operates a Personal Support Network for all remote health workers, service managers and their families. The services provided include the Bush Crisis Line (BCL) - a 24 hour telephone service - self-help booklets and a "Surviving Stress" workshop.
- Lifeline provides a 24 hour telephone counselling and referral service from centres across the country but cannot be described as a nationwide service. The organisation is currently developing a database with national coverage to underpin the operation of a national information hotline: "Just Ask". It is planned the database will comprise

information on referral services nationwide relating to a wide range of issues, including violence-related support. The plan is to initially trial the database and “Just Ask” through four of Lifeline’s 43 centres and to later provide access to all Lifeline Centres. The final stage will involve website access to the database. It is anticipated that website access will be available by 2003.

- 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. Centrelink also has an articulated service strategy to respond to victims of violence (Centrelink 1998). As noted earlier, service provision is focussed on presenting clients but Centrelink staff are expected to collaborate with other service providers.

5. CONCLUSIONS

5.1 The types, prevalence and severity of violence

The overall picture that emerges from the literature is that much quantitative work on the extent of violence in rural and remote areas remains to be done. Published official statistics tend to focus on disaggregation by jurisdiction not by region, and other work tends to be patchy.

The general violence statistics suggest that there are not large differences between metropolitan and non-metropolitan areas. However, where data exist for urban, other urban and rural or remote areas it suggests greater differences. The literature does not indicate that violence associated with alcohol consumption or abuse is a greater problem in rural areas than in urban areas.

Firearms related violence is clearly more of an issue in rural and remote areas, reflecting the greater availability of firearms in those locations.

The most comprehensive work on domestic/family violence that specifically discusses rural areas tends to agree that there is no real knowledge about the incidence of domestic violence in Australia – in rural areas or elsewhere. However, the available material suggests there are higher rates in rural and remote Australia, particularly in Indigenous communities. The limited literature that deals with violence involving Indigenous people in rural and remote Australia – as distinct from Indigenous communities – also supports this view.

However, what data there are would seem to indicate that:

- Domestic/family violence in all its forms accounts for by far the greatest proportion of violence.
- Women experience domestic violence at greater rates than men.
- Little is known about the prevalence of or trends in different forms of domestic/family violence.

- The number of Indigenous women included in the 1996 ABS survey and the Women's Health Australia study is too small for estimates to be made of incidence and prevalence of domestic and sexual violence.

In relation to violence towards health workers in rural and remote areas, while the literature suggests that there are high rates of violence it also highlights the lack of substantial evidence.

Finally, although rural and remote areas have a greater proportion of aged people than urban areas, it is noteworthy that there is no literature on violence towards the aged in rural and remote areas.

5.2 Suicide and self-harm

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

- There has been a marked increase in suicide among young males in rural areas across Australia over the last two decades.
- The availability of firearms in rural areas contributes to a high rate of firearms suicide in rural areas.
- There is evidence of increasing rates of suicide in traditionally-oriented Indigenous communities.

There is very little material on other forms of self-harm.

5.3 Barriers to the effective management of violence by health workers

There is limited material relating to barriers to effective management of violence by health 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 are also recommended, as is the maintenance of current information about services and legal issues.

5.4 Resources available to health workers

While there is a range of resource and education kits on the management of violence for health workers, the majority of the material deals with domestic violence and potential violence from clients. There is little material on other forms of violence and few reports of evaluations of the effectiveness of kits. However, there is a very substantial literature on government and community strategies seeking to reduce violence and its effects in rural and remote areas, some of which will provide a context for health workers addressing violence.

There are also a number of websites potentially of use to health workers which provide information on forms of violence, references, links to other sources and service or support contact details.

5.6 Gaps in the literature/research

There is a clear need for robust measurement of the incidence and prevalence of violence in rural and remote Australia, including violence related to the aged, as the currently available data are both limited and patchy. (There are indications that the relevant data may have been collected, possibly by ABS and AIHW, but is not in accessible form.)

The next most important research gap, given the present profile of violence in rural and remote Australia, is the nature of the relationship between being a victim of/exposed to person to person violence and self harm/suicide.

More research is also needed on course content and approaches related to providing appropriate education and professional support for rural and remote health workers.

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