

"Context of Silence"

*Violence and the Remote
Area Nurse*

FACULTY OF HEALTH SCIENCE



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Central Queensland
U N I V E R S I T Y

“CONTEXT OF SILENCE”

VIOLENCE AND THE REMOTE AREA NURSE

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SUMMARY OF CONCLUSIONS

Level and perception of violence

- Evidence from the study suggests that remote area nurses are living with frequent threats to their personal safety whilst on duty, on call and off duty, and that violent incidents are often handled badly both by employers, the community, and by remote area nurses themselves.
- Twenty four hour on call is an employment requirement for 82% of respondents. Those required to be on call 24 hours experience episodes of violence more frequently.
- Despite nearly all of the respondents experiencing episodes of violence within the previous 12 months of the study, there was a tendency for remote area nurses, except in the case of physical violence, to perceive both the frequency and severity of their experiences with violence as low, and not personally directed.
- The community context of violence was stressed by the majority of remote area nurses, with most prevention strategies suggested focusing on community involvement and changes. Alcohol was identified as the major cause of violence.

Coping and educational requirements

- The majority of respondents did not feel adequately prepared for the reality of their current work. Many (46.9%) did not receive any orientation program prior to starting work in their present position, and 30.8% have not yet received any orientation or inservice program since starting their current jobs.
- Cross cultural information was received by 53.6% of respondents, and only 24.3% were given information related to the issues of personal safety. The majority of those who did receive this information perceived both the cross cultural input and the personal safety input to be inadequate.
- Community expectations regarding the role for the remote area nurse was identified by the respondents to be frequently unrealistic, with expectations that the nurse was there to serve the community both day and night, any place, any time.
- The majority of remote area nurses perceive their coping skills as effective, although 76.3% stated they wished to learn more effective coping strategies. The most commonly identified coping mechanisms were to attempt (frequently unsuccessfully) to get the Police, or to try to ignore the problem.

Role of employer and perceptions of support

- Nearly half of the respondents felt the level of professional support they received did not meet their working needs. Many (25.5%) were the only health professional in their community. Only 58.8% of respondents stated that they were working in health settings which were fully staffed. 73% did not have access to a doctor in the community in which they worked, with only 52.6% being visited by a doctor at least weekly or fortnightly. Nearly all of the remainder stated they were either never visited by doctors, visited only in emergencies, or visited monthly.
- Apart from offers to evacuate, the respondents stated there was little or no support forthcoming from employers after incidents of violence were reported. Perhaps as a result, only 52.8% of respondents indicated that they always officially reported incidents of violence. A significant number (32.8%) indicated that as a result of previous experiences with their employer (regarding reporting violent incidents), they no longer felt confident about reporting violent incidents to them.

Stress and perception of personal safety

- Over one third of the respondents indicated they fear for their personal safety, and a significant number did not feel safe in their work or in their home.
- 51% of the respondents have no access to a security escort when on call, and a large number feel that security is not maintained adequately where they live and work.
- The stress associated with living with violence and fear for their safety was compounded by organisational stressors such as; staff shortages, working long hours, having holidays cancelled, poorly prepared relief staff and low levels of employer support.

RECOMMENDATIONS

1. That the Federal Government, each State and Territory government and employing bodies acknowledge that Remote Area Nurses suffer substantial risk of violence both threatened and real.
2. That Federal, State and Territory governments and employing bodies as a matter of urgency:
 - acknowledge that the current situation is unacceptable;
 - develop formal and informal mechanisms to provide:
 - appropriate and adequate 24 hour debriefing and post-trauma services for RANs and other health staff (these may be required to be independent of the employing body);
 - RANs with appropriate support including time off, adequate relief and time out of the community;
 - establish regular support networks for all health professionals working in geographical and professional isolation;
 - orientate all administrators of remote area health care to the occupational health and safety needs of remote area health staff;
 - provide adequate and safe housing, workplace, maintenance and security systems.
3. That the Federal Government, State and Territory governments and employing bodies make a firm commitment to:
 - develop policy in conjunction with RANs, employers and remote area consumers to protect the occupational health and safety needs of RANs;
 - provide funding to develop geographically and culturally appropriate orientation programs which are compulsory for all RANs prior to employment in remote areas. The program should include components on:
 - cross cultural awareness;
 - crisis intervention techniques;
 - violence management and prevention;
 - maintenance of support networks in the community;
 - overall structure of the health service and its role in the community;
 - stress management strategies;and that this orientation program be developed in consultation with RANs, employers and remote area consumers;
 - providing tangible support for community councils and relevant government authorities in enforcing existing laws in the sale and distribution of alcohol in all remote communities.

- providing tangible support for community councils and relevant government authorities in enforcing existing laws in the sale and distribution of alcohol in all remote communities.
4. That regional tertiary institutions, in particular, and all institutions which provide distance education for health professionals include relevant subjects in programs which explore issues of primary health care, cross cultural service provision, violence management and prevention, the application of appropriate counselling and crisis intervention techniques.
 5. That research be instigated exploring issues of safety for Aboriginal and Torres Strait Islander Health Workers.

ABSTRACT

Anecdotal evidence exists to suggest that the incidence of violence directed towards remote and rural health professionals is severe and increasing. Furthermore, some remote area nurses have reported increasing evidence of violent interactions as a significant motivation for their departure from remote area nursing practice. Limited research has been conducted which specifically addresses the risk and experience of violence to health professionals who practice in remote communities.

The Federal Government has accepted that violence is a problem in rural communities across Australia (National Committee on Violence Against Women 1992). The 2nd National Rural Health Conference recommended that: "rural communities be resourced to develop their own appropriate strategies for health programs such as STD/HIV control, violence and substance abuse" (Malko 1993, p.249).

The purpose of this study was to explore the anecdotal evidence that violence is a prevalent stressor to remote area nurses within isolated communities, and to assess their repertoire of coping skills in effectively managing violent situations. The study utilised 'across method triangulation' combining quantitative (in the form of a questionnaire survey of remote area nurses) and qualitative methods (in the form of open ended questions) within the questionnaire and group interviews of voluntary participants.

Findings from this study indicate that a majority of remote area nurses experience frequent and serious episodes of violence with verbal abuse, property damage and physical violence most common. Living with fear for personal safety is a major stressor, and is frequently compounded by organisational induced stressors such as short staffing, 24 hour on call requirements, a lack of adequate orientation and cultural awareness education, and low levels of employer support. The majority of respondents perceived their coping skills as adequate, although 76.3% stated they wished to learn more effective coping strategies. The most commonly identified coping mechanisms were to attempt (frequently unsuccessfully) to get the police, or to try to ignore the problem. Perhaps of greatest concern was the identified lack of support once a violent incident occurred. A significant number of respondents indicated that as a result of their experiences with their employer, they no longer felt confident reporting violent incidents.

Violence against remote area nurses is a fundamental violation of their human rights. Acknowledgement of remote area nurses as victims of a blame-free traumatic event is of critical importance in the development of policies and intervention programs to address the issue of personal safety of remote area nurses.

1 INTRODUCTION

1.1 Introduction to the study

The study aims to explore anecdotal evidence that suggests violence directed towards remote area nurses (RANs) is increasing, is a prevalent stressor in remote area nurses' practice, and that RANs are ill equipped in managing these violent incidents. The impetus for this research project arose through a combination of factors:

- the first hand knowledge of issues through some of the researchers' previous experiences as RANs;
- reports from RANs to the researchers when supervising nursing students on clinical placements;
- media reports highlighting safety issues.

The Federal government has acknowledged that violence is a problem in rural and remote communities across Australia (National Committee on Violence Against Women 1992). The 2nd National Rural Health Conference recommended that: "rural communities be resourced to develop their own appropriate strategies for health programs such as STD/HIV control, violence and substance abuse" (Malko 1993, p.249).

Violence against women has been recognised as a serious national problem that "Australians can neither afford to condone nor allow to continue" (National Committee on Violence Against Women 1992, p.1). As RANs are predominately women (90.8% of respondents), research which identified and clarifies the occurrence and type of violence that is being experienced by remote area nurses is very relevant to the National Strategy on Violence Against Women.

Consequently, this research shares many of the same methodological complexities as that of studying violence against women in the general community where surveys and research show that violence against women goes mainly unreported and that women may live as silent victims with unresolved guilt, fear and anxiety associated with their experience (National Committee on Violence Against Women 1992).

1.2 Aims of research

As a step in redressing the paucity of data on the experience and description of violence against RANs, the aims of our research were threefold:

- To determine the frequency and severity of violent incidents occurring against nurses in remote communities.
- To determine whether violence is perceived as a stressor by these RANs.
- To identify whether this population perceive that they have the repertoire of coping skills necessary to effectively manage violent situations.

The original research design included surveying Aboriginal and Torres Strait Islander Health Workers (ATSIHWs) on their perceptions of violence. However difficulty in receiving ethical clearance from some Regional Health Authorities meant the researchers were unable to fulfil this goal. Thus, although four ATSIHWs responded to the questionnaire, the overwhelming majority of respondents were RANs and consequently respondents will be referred to as RANs throughout this report.

2. BACKGROUND TO THE STUDY

2.1 Introduction

RANs have existed in remote parts of Australia for over 100 years. Documented evidence indicates the employment of RANs in Kalgoorlie and Coolgardie in Western Australia in the 1890s (Kreger 1991). Today, there are 217 remote nursing outposts in pastoral, railway, mining and Aboriginal and Torres Strait Island communities. The Remote Area Nurse (RAN) has been an integral part of Australia's answer to meet the health care needs of people who are disadvantaged through geographical isolation.

More consistently than any other professional in Australia, it has been the nurse who has "gone outback" to meet these needs(Johnson, 1992).

A significant aspect of the RAN's role is that these professionals most often practise without the benefit of immediate medical, ancillary and/or other support personnel (Cramer 1992; 1994). Because of this isolation and lack of other health services, the nature of the RAN's work is unique within nursing. Frequently they are expected by their communities to perform duties well beyond the scope of what is normally considered within a nursing role. They are often the only health worker in the community who is responsible for emergency care, and as a result are on call 24 hours a day, 7 days a week. Moreover, the working conditions, accommodation and health care resources they can access are frequently substandard (Cramer 1992; 1994; Kreger 1991).

Compounding these problems is the fact that the RAN's employer organisation is often located many hundreds of kilometres away - sometimes several days travelling time overland. At times the employers appear to be either unaware, or uninterested in the variety and seriousness of the demands placed upon RANs (Cramer 1992).

Living, working and socialising within remote communities can present significant personal and professional challenges, and stress for nurses. (Kreger 1991, p.5).

2.2 Violence and nursing

The literature recognises that the type of violence and violent behaviours that occur against health professionals have been greatly under researched (Engel & Marsh 1986; Ryan & Poster 1989; Lanza 1983; Lion, Snyder & Merrill 1981). Prior to 1983 there was little Australian research into violence experienced by nurses. A retrospective study by Lanza (1983) focusing on nursing staff

assaults over a one year period found that although a significant number of nurses were experiencing violent incidents, they were choosing to remain silent. A major study published by the Royal Australian Nurses Federation (Holden 1985) revealed that out of 310 nurse respondents:

- 85.8% (266) nurses had experienced aggression by patients;
- 43% of these had experienced abuse on 1-4 occasions in the previous 12 months;
- 15.8 % of respondents reported abuse more than 25 times in the same period.

These figures represented verbal aggression as well as physical assault.

Compounding this lack of research is the difficulty in accurately assessing both the frequency and severity of violent incidents. This difficulty has been linked to a phenomena of under reporting across all of the relevant literature. Engel and Marsh (1986) cite several researchers who have evidenced and statistically validated the significant gap in reported episodes of violence and those actually experienced by health professionals including psychiatrists, psychologists and registered nurses. The literature suggests that at times when nurses do have the courage to report violent incidents, their employer and colleagues frequently respond by identifying the individual's nursing and interpersonal skills, or lack of these, as somehow having caused or contributed to the problem (Bowie & Malcolm 1989). These authors suggest that blaming the victim assists other staff members to distance themselves from the possibility of they, themselves, being a victim of abuse.

2.2.1 Violence and remote area nursing - the context of silence

The issue of personal safety for RANs living in remote areas has been noted in a number of State and Regional reports (Brown 1992; CRANA 1992; Cramer 1994). However, to the knowledge of this research group, no systematic attempt to gather data on the incidence of violence experienced by RANs and other remote area health workers has occurred. Anecdotal evidence and personal communication from RANs to the Council of Remote Area Nurses of Australia (CRANA), suggests that the incidence of violence directed towards RANs is high and is increasing. Examples of such anecdotal evidence include the following: one experienced RAN had her house broken into 21 times in a 12 month period; verbal violence and abuse are reportedly daily occurrences for many RANs (Smith 1993).

The literature suggests that the problem with quantifying the incidence of violence is that there tends to be a 'context of silence' over the rate and type of

assaults made on health professionals. Where RANs feel they may lose their jobs, or be blamed by their community or their employer for the violent event, they may understandably be reticent in raising community awareness of the amount of violence occurring, or in drawing attention to themselves and/or their job conditions. RANs may also choose to downplay the level of violence that exists, in particular in Aboriginal communities to 'protect' the communities themselves from a society who has often failed to understand the complexity of cultural relationships and the influence of colonisation on Aboriginal and Torres Strait Islander people. Resignation may be viewed as a more attractive alternative, further reinforcing the 'context of silence'. Some RANs in Queensland have reported increasing violent interactions as a significant motivation for their departure from remote area nursing practice (McDonald 1993; Robins 1994). Johnson (1993) reports that a turnover rate of 200 percent per year for RANs is typical for many of these communities. Anecdotal evidence from a remote area nurse indicated that one community in Queensland in 1993 had a turnover of 600% (Smith 1995).

Moreover, the very nature of nursing care and the requirement for close physical contact, creates for the often isolated RAN, a greater potential to be a victim of violence than other professionals in remote areas such as teachers. Other professions, who may also face violence, are more likely to have a greater capacity to physically withdraw from violence than the RAN who maybe in close proximity to the perpetrator, is frequently on call 24 hours, works at night and cares for people in a variety of community contexts.

Further perpetuating this 'context of silence' is the courage of RANs themselves. These nurses go beyond romantic dreams of 'going bush' and make an active decision to become a part of that folk lore. It takes a particularly adventurous spirit and courage to travel to, and decide to live in an isolated region, let alone to take on the roles and responsibilities of being the only health professional. This spirit and courage has the potential for adding to the context of silence as is encapsulated in an interview reported in Kreger (1991 p.21);

Jill: Sally actually had a person with a shotgun one night threatening and firing shots.

Sally: Yeah.. ...It's sort of distracting when you are trying to think of your diagnosis.

It is possible that this 'context of silence' has contributed to the paucity of research, documentation, and public discussion on the issue of personal safety and the RAN.

2.3 Nurse's response to violence (stress and coping)

There are limited studies which describe nurses' responses to violence, the type of coping skills they employ or the results of follow up intervention programs giving support to the victim. It is well known, however, that episodes of violence are experienced and interpreted as significant emotional and/or physical traumas for the receiver (Lanza 1983; Lion et al 1981; Holden 1985). Ultimately, these experiences contribute to physical harm, emotional instability, fear for personal safety, lack of job satisfaction, stress, high staff turnover rates and other chronic or pathological forms of mental and emotional distress for the health worker (Engel & Marsh 1986).

Holden (1985) suggested that many nurses found it impossible to outwardly express their anger or fear and consequently found other indirect methods of dealing with these lingering feelings. Many nurses reported feeling "unprofessional" when expressing their emotional responses to violent experiences and were reluctant to acknowledge their feelings, or to even press charges (Lanza 1983).

A remarkable feature in the literature throughout the 1980s is that the employee, or victim, was not only blamed in some way, either directly or indirectly, by colleagues, co-workers and hospital administrators for provoking the violent incident (Bowie & Malcolm 1989), but they were also denied access to counselling or follow-up debriefing by their employers. The literature has been clear in advocating that all professionals and persons who are assaulted require debriefing and post-trauma counselling (Hume 1993; Hoff 1989; 1990; Bolger 1991). In many situations, where nursing staff have experienced violent incidents in their work place, peer support groups have been formed in order to facilitate a positive resolution for the victim of the violent or fear-provoking incident (Dawson, Johnston, Kehiayan & Kyanko 1988).

However, support must go beyond the immediate or "on the spot" discussion that is provided by colleagues or friends, and should entail formal intervention programs such as those provided by victim assault teams, peer support or victim assistance programs (Ryan & Poster 1989). Janoff-Bulman (1985) suggests that being a victim of violence calls into question one's basic assumptions associated with one's world view. This process has the potential to destroy the individual's perception of, and ability to function in a stable and orderly world. Consequently, when a violent episode occurs the victim's world no longer feels safe or orderly. Similarly, it goes without saying that any client or person who witnessed the violent incident may also require similar debriefing and assurances.

2.4 RAN's response to violence

The provision of therapeutic interventions is made extremely difficult through the isolation and remoteness experienced by remote area nurses and ATSIHWs in Australia. These professionals are often geographically inaccessible to backup teams should they require sick leave or special leave for counselling. Similarly, they are often faced with the role conflict of returning to a work environment where they may have to face and/or continue to care for their assailant who may be awaiting charges or even not charged (Lanza 1983). The RAN usually lives near, or even within the same community as their assailant, is geographically isolated, and has little or no opportunity to shift the responsibility of care for that client to another health worker. Fear and anxiety must escalate in such a situation, along with the awareness of the possibility that the assailant may seek retaliation if reported.

2.5 Employer responsibilities

Lack of educational preparation has also been identified as affecting outcomes from potentially violent situations. Many reports have focused on the inadequate preparation for rural and remote practice for all health professionals (Gray & Buckley 1992; Kreger 1991; National Rural Health Strategy 1991; Brown 1992; CRANA 1992; Cramer 1994). Each of these reports stress the necessity of improved education of RANs as crucially important in the preparation for rural and remote area practice and the extended role nurses are required to adopt in these communities. Hume (1993, p.90) suggests that "staff should be selected and trained in communication and interpersonal skills...and made familiar with the premonitory signs of violence." Other educational issues for RANs identified include:

- lack of or inadequate cross-cultural education;
- lack of or inadequate initial preparation for rural and remote practice;
- lack of or inadequate continuing education opportunities;
- lack of professional and personal support by their employer to allow RANs time off and relief to attend conferences and other professional development programs.

Employers have a responsibility under State and Territory occupational health and safety regulations to provide a safe and secure environment for RANs to live and work in. A number of reports have discussed the inadequate and unsafe working conditions and accommodation provided for RANs by their employers (Brown 1992; CRANA 1992). These occupational health and safety issues may threaten the personal safety of the RAN and contribute to the very high staff turnover rates in some communities.

3. METHODOLOGY

3.1 Design

Across-method triangulation, combining quantitative and qualitative methods of data collection, was utilised in this study in order to increase the validity of the findings. The use of triangulation was chosen to ensure a richer data base, give rise to a more complete picture of the phenomenon of violence as it is experienced by this population and to increase the level of confidence in the capacity for the results to be generalised (Mitchell 1986). Figure 1 illustrates the design of the study.

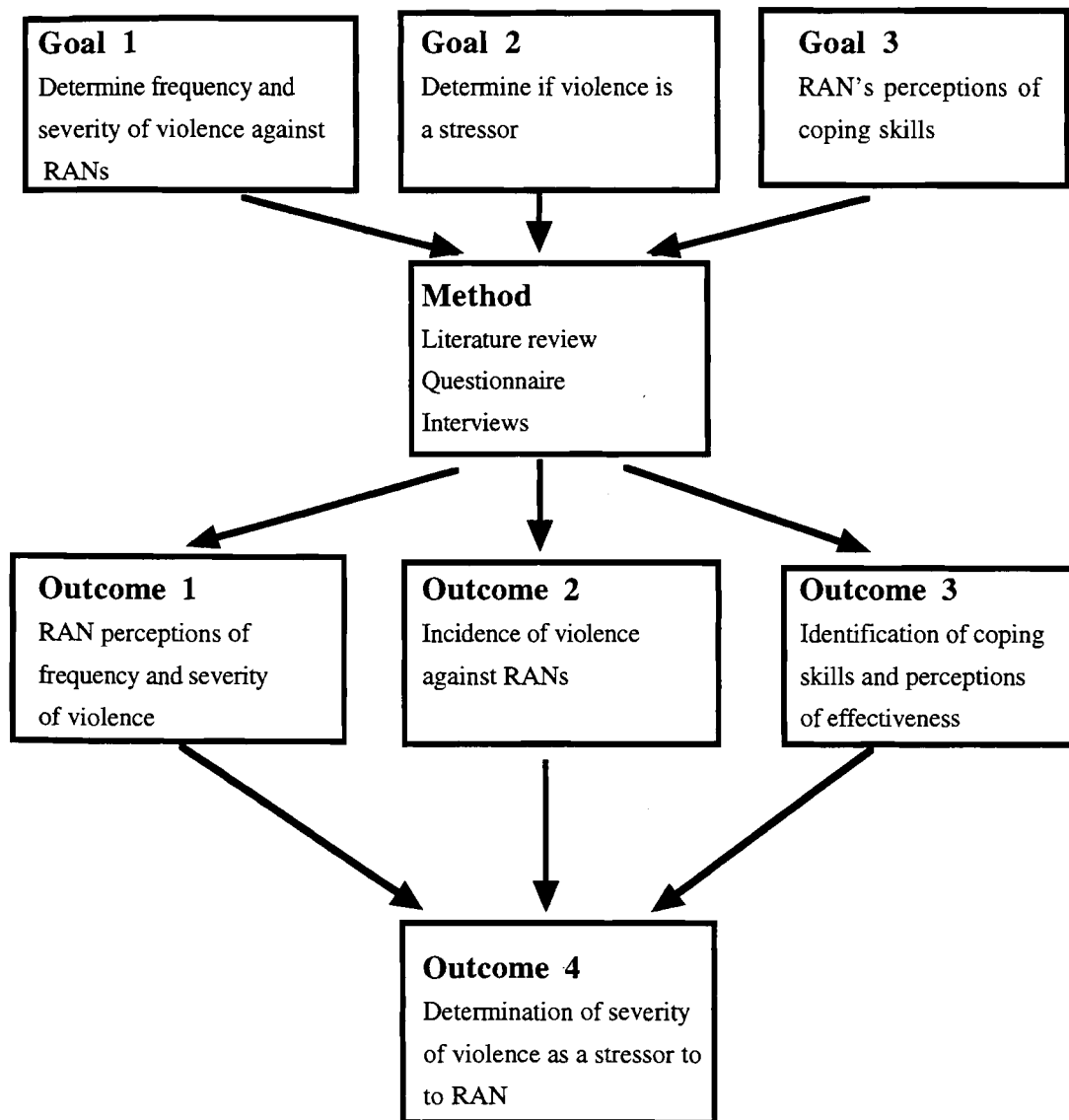


Figure 1. Design of study

Two research methods were selected to answer the three research questions. The first method comprised a questionnaire of closed and open ended questions on the RAN's experiences with violence and related issues. The second method consisted of unstructured interviews with 'volunteer' RANs to cross-validate the findings from the questionnaire and provide invaluable qualitative information on the issues surrounding the safety of RANs.

Ethics approval was granted by Central Queensland University, and consultation with Aboriginal and Torres Strait Islanders at Federal, State and Community levels occurred throughout the research process.

3.2 Sample

The sample was a convenience sample and consisted of members of CRANA who responded to a questionnaire included in their newsletter.

CRANA was chosen as a means of obtaining a sample of RANs as the researchers were experiencing difficulty in obtaining ethical clearance from the relatively new Regional Health Authorities within Queensland. Most of these Authorities had not formed ethics committees or were in the process of establishing one. Moreover, using CRANA gave the researchers access to RANs throughout Australia.

3.3 Questionnaire

The questionnaire was developed from information gained through a literature review and discussions with remote area nurses. Violent incidents related to verbal aggression and obscene behaviour, property damage, telephone threats, stalking, physical violence, sexual harassment and sexual abuse were examined. Each type of violence identified was accompanied by a plain English definition as outlined in Appendix 1.

The questionnaire was divided into 6 parts. **Parts A and B** elicited information on the demographic variables of the respondents including:

- the community in which they were employed;
- the level of professional support they received;
- the sense of belongingness they felt towards the community they served.

Part C inquired about the level of orientation and inservice programs offered, and the respondent's perceptions as to the adequacy of these in preparing them for the reality of their nursing practice. **Part D** assessed the frequency and

severity of violence experienced by RANs and perceptions of the effectiveness of coping strategies utilised. **Part E** ascertained whether RANs reported incidents of violence and to whom. **Part F** assessed security systems in both health care settings and accommodation and the perceptions of the respondents as to their adequacy. The final section in **Part F** asked the respondent to describe an incident that had affected them within the last 6 months.

A pilot version of the questionnaire was distributed to 12 RANs, five nursing academics, and 2 ATSIHWs who discussed it with colleagues and community members. Revision of the questionnaire occurred as a result of the weaknesses identified in this pilot study.

The questionnaires, including a return addressed envelope, were sent with the CRANA newsletter to all members of CRANA. The completed questionnaires were then returned by mail to the researchers. Follow-up procedures included a reminder letter and an offer of assistance. No further follow-up procedures were initiated.

Data from the questionnaire was analysed by computer (using Minitab) to generate frequency distributions and cross-tabulations. Most of the questionnaire involved categorical data and was analysed by a chi-square non-parametric procedure. The Likert rating scales were assigned numerical values with any options between positive and negative being considered to be along a continuum. See Appendix 2 for a copy of the questionnaire.

3.4 Interview

Respondents to the questionnaire were invited to take part in an interview through a teleconference with other participants and researchers. This method of data collection was chosen to allow exploration of perceptions and feelings related to issues of safety. To indicate a desire to be part of the teleconference, respondents were requested to return a signed consent form along with their questionnaire.

The teleconference took place at a date and time negotiated between researchers and the participants. A total of six respondents indicated their willingness to be a part of the teleconference, however only four were able to actually participate. Two researchers conducted the teleconference and one other researcher was available to prompt and take notes. The interview was largely unstructured with the participants only given the aims of the teleconference. The proceedings were taped by Telecom.

4. RESULTS

In this section, results will be discussed under the relevant research method.

4.1 Questionnaire

There was an overall response rate in terms of usable questionnaires of 41.35%. Table 1 shows number of RANs receiving the questionnaire in each state/territory and the response rate for each state.

State	Number of RANs receiving questionnaire	Response Frequency (%)
Queensland	88	37 (42%)
Northern Territory	53	29 (54.7)
Western Australia	34	11 (32.3)
New South Wales	22	6 (27.3)
South Australia	22	5 (22.7)
Victoria	16	5 (31.3)
Tasmania	1	1 (100)
Australian Capital Territory	1	1 (100)
Unknown		3

Table 1: *Number of questionnaires sent and response rate by State/Territory*

4.1.1 Demographic details and experience of violence

Results showed that the majority of respondents were female (90.8%), aged between 30 and 50 years (73.4%) and experienced RANs. 77.5% of respondents had worked in remote areas between two and five years, and 43.8% for more than five years. Table 2 shows length of employment in current community and total length of employment as a RAN.

There were minimal differences between the age groups of the respondents and their experiences of violence, except for the group aged 20 - 29 years who were more likely to experience sexual harassment both on duty (chi-square = 8.665, d.f. = 3, $p=.05$) and on call (chi-square = 9.326, d.f. = 3, $p = .05$).

There was a trend indicating that male RANs were more likely to experience violence than female RANs. However, although representative of the total number of male RANs, the number of male respondents was low ($n=8$ or 8.2%

of sample), and caution must therefore be used in drawing conclusions from this finding.

Length of employment as RAN	In remote communities Frequency (%)	In current community Frequency (%)
Less than 1 month	0 (0%)	2 (2%)
2 - 6 months	1 (1)	14 (14.5)
7 - 12 months	7 (7)	17 (17.7)
13 - 23 months	14 (14.2)	22 (22.9)
2 - 5 years	33 (33.6)	22 (22.9)
more than 5 years	43 (43.8)	19 (18.7)

Table 2: *Length of employment in remote communities*

As can be seen in Table 3, which gives frequency distributions of respondents' experiences with the different types of violence covered in the questionnaire, a significant number of nurses experienced violence of all types within the past 12 months.

Type of violence experienced	Frequency (%)
Verbal aggression and obscene behaviour	69 (82.1%)
Property damage	43 (46.7)
Physical violence	42 (45.1)
Sexual harassment	29 (31.8)
Telephone threats	16 (17.0)
Sexual abuse	10 (10.6)
Stalking	8 (8.3)

Table 3: *RAN's experience with violence within the past 12 months*

	Verbal aggression & obscene behaviour	Property damage	Physical violence	Sexual harassment	Telephone threats	Sexual abuse	Stalking
Frequency							
(1) = Low	27 (32.9%)	27 (55.1)	17 (37.7%)	16 (47%)	13 (65%)	6 (54.5%)	5 (55.5)
(2)	21 (25.6)	14 (28.5)	18 (40.0)	8 (23.5)	4 (20)	2 (18)	3 (33.3)
(3)	17 (20.7)	6 (12.2)	5 (11.1)	7 (20.5)	3 (15)	2 (18)	0 (0)
(4)	12 (14.6)	0 (0)	3 (6.6)	2 (5.8)	0 (0)	0 (0)	1 (11.1)
(5) = High	5 (6.0)	2 (4.0)	2 (4.0)	1 (2.9)	0 (0)	1 (9)	0 (0)

Table 4: *Perceived frequency of violent experiences*

Verbal aggression and obscene behaviour were most frequently experienced with 82.1% of respondents reporting this violence as occurring to them within

the past 12 months. However, as illustrated in Table 4 and Table 5, there was a tendency for RANs to rate both its frequency and severity as low.

	Verbal aggression & obscene behaviour	Property damage	Physical violence	Sexual harassment	Telephone threats	Sexual abuse	Stalking
Severity							
(1) = Low	14 (17%)	4 (8%)	5 (11.1%)	10 (31.2%)	3 (15%)	0 (0%)	2 (22.2%)
(2)	21 (25.6)	14 (28.5)	9 (20)	8 (25)	4 (20)	1 (9)	1 (11.1)
(3)	19 (23.1)	15 (30.6)	8 (17.7)	9 (28.1)	8 (40)	2 (18)	2 (22.2)
(4)	21 (25.6)	12 (24.4)	13 (28.8)	4 (14.5)	5 (25)	5 (45.4)	1 (11.1)
(5) = High	7 (8.5)	4 (8)	10 (22.2)	1 (13.1)	0 (0)	3 (27.2)	3 (33.3)

Table 5: *Perceived severity of violent experiences*

Property damage, followed closely by physical violence were the next most commonly experienced types of violence. Again, as can be seen in Tables 4 and 5, there was a tendency to rate the frequency low, however the severity was rated higher, particularly in the case of physical violence.

The perception of coping increased with experience, with a trend indicated for those RANs with less than 12 months experience in their current community to believe they coped ineffectively with violence. This trend was significant with sexual abuse (chi-square=32.833, d.f.=20, p=.05).

As indicated in Table 6, the respondents on the whole were highly qualified, with 23.4% holding a degree in nursing and the majority holding two certificates.

Qualification	Frequency (%)
General Nurse Certificate	89 (90%)
Registered Midwife	64 (65)
Degree in Nursing	23 (23.4)
Child Health Certificate	18 (18.3)
Psychiatric Nursing Certificate	5 (5)
Certificate in Aboriginal and Torres Strait Is. Primary Health Care	4 (4)

Table 6: *Qualifications of respondents*

4.1.2 Employment conditions and relationship to the experience of violence

Thirty five per cent of respondents were employed in communities with less than 500 people, 36% in communities with population between 501 and 1200, and 21.9% in communities with population between 1201 and 3000 people. Only 6% of respondents worked in communities with more than 3000 people. Although respondents experienced violence in all sized communities, the results suggested that the experience of violence was greater in small communities of less than 1200. This was significantly so in relation to verbal and obscene behaviour, both on duty (chi-square=13.257, d.f.=3, p=.01) and on call (chi-square= 11.532, d.f.=3, p=.01).

Respondents working as the only RAN in a community totalled 29.3%, with 30.4% working with one other registered nurse. 25.5% of respondents worked in total isolation without support from any other health professionals. Only 58.5% of respondents stated they were working in health settings which were fully staffed. Table 7 shows the distribution of the numbers of RANs and all other health professionals within the respondents' workplace. There appeared to be no relationship between the numbers of RANs employed in a community and the amount of violence they experienced.

Number of other workers	Other nurses Frequency (%)	Other health professionals Frequency (%)
None	27 (29.3%)	23 (25.5%)
1	28 (30.4)	5 (5.5)
2 - 5	28 (30.4)	38 (42.2)
More than 5	9 (9.7)	24 (26.6)

Table 7: *Number of other RANs and health professionals in each respondent's community*

Type of violence experienced	On call 24 hours Frequency (%)	Not on call 24 hours Frequency (%)
Verbal aggression and obscene behaviour	61 (88.4%)	8 (11%)
Property damage	40 (93)	3 (7)
Physical violence	38 (92.6)	3 (7)
Telephone threats	14 (87.5)	2 (12.5)
Stalking	8 (100)	0 (0)
Sexual harassment	24 (82.8)	5 (17.2)
Sexual abuse	9 (90)	1 (10)

Table 8: *24 hour on call and experiences with violence*

Twenty four hour on call was an employment requirement for 82% of respondents. As illustrated in Table 8 those RANs required to be on call on a 24 hour basis, were more likely to experience violence. This result was significant for incidents of verbal aggression and obscene behaviour (chi-square=9.225, d.f.=1, p=.01), property damage (chi-square=6.029, d.f.=1, p=.05) and physical violence (chi-square=5.859, d.f.=1, p=.05).

The level of medical (doctor) support services varied markedly within the sample. Seventy three per cent of respondents did not have access to a doctor in the community in which they worked. The majority (52.5%) were visited by a doctor either weekly or fortnightly. Table 9 shows the frequency of access respondents had to medical services.

Frequency of access	Number of respondents Frequency (%)
Never	5 (5.3%)
Emergencies only	15 (16)
Twice per week	2 (2)
Weekly	28 (30)
Fortnightly	21 (22.5)
Monthly	9 (9.6)
Other	13 (14)

Table 9: Access to medical/doctor services

4.1.3 Perception of professional support

In order to assess perceptions about the level of professional support, Likert scales assessing levels of agreement to the statement "*the level of professional support I receive meets my working needs*" were utilised. As indicated in Table 10 a high proportion (44.2%) disagreed with the statement while only 26.7% expressed agreement.

Level of agreement with statement	Frequency (%)
(1) = strongly disagree	12 (12.3%)
(2)	31 (31.9)
(3)	27 (27.8)
(4)	21 (21.6)
(5) = strongly agree	5 (5.1)

Table 10: Perceptions of level of professional support

The majority of respondents did not feel adequately prepared for the reality of their current work. Many (46.9%) did not receive any orientation program prior to starting work in their present position, and 30.8% have not received any orientation or inservice program since starting in their current jobs.

Cross cultural information was received by only 53.6% of respondents, and 24.4% were given information related to the issue of personal safety in remote communities in an orientation or an inservice program. As indicated in Table 11, 65.2% of respondents believed the cross cultural information they received was inadequate, and 76.8% believed the information on personal safety was also inadequate preparation for the reality of their current work.

Level of agreement with statement	Cross cultural information adequate Frequency (%)	Personal safety information adequate Frequency (%)
(1) = strongly disagree	24 (33.3%)	31 (44.9%)
(2)	23 (31.9)	22 (31.9)
(3)	16 (22.2)	10 (14.5)
(4)	8 (11.1)	6 (8.7)
(5) = strongly agree	1 (1.4)	0 (0)

Table 11: Perceived adequacy of cross cultural and personal safety information

4.1.4 Sense of belongingness to community

Table 12 indicates level of agreement with the statement:

"I feel a true sense of belongingness to the community in which I work".

As can be seen in the table, 25% of respondents did not feel a true sense of belongingness to their community. There was an inverse relationship between sense of belongingness and fear for personal safety; the higher the sense of belongingness to the community in which they worked, the less fear was experienced. For example, those respondents who strongly disagreed with this statement were significantly more likely to fear for their personal safety whilst on duty (chi-square = 9.794, d.f.=4, p=.05), off duty (chi-square= 11.426, d.f.=4, p=.05) and whilst on call (chi-square = 15.171, d.f.=4, p=.01). Whereas those who strongly agreed with the statement were the least likely to fear for their personal safety. Except in the case of telephone threats and sexual harassment, there was little or no relationship between sense of belongingness to their community and incidents of violence experienced. For example, in the case of physical violence, even those RANs who felt a very strong sense of

belongingness to the community were just as likely to experience physical violence.

Level of agreement with statement	Frequency (%)
(1) = strongly disagree	7 (7.2%)
(2)	17 (17.7)
(2)	25 (26.0)
(4)	34 (35.4)
(5) = strongly agree	13 (13.5)

Table 12: *Perceptions of sense of belongingness to respondent's community*

4.1.5 Coping skills/strategies

	Verbal aggression & obscene behaviour	Property damage	Physical violence	Sexual harassment	Telephone threats	Sexual abuse	Stalking
Level of effectiveness							
(1) = not very effective	1 (1.2%)	8 (17%)	9 (19.1%)	4 (12.5%)	2 (10%)	1 (9.1%)	1 (11.1%)
(2)	16 (19.8)	8 (17)	13 (27.7)	7 (21.9)	3 (15)	2 (18.2)	0 (0)
(3)	16 (19.8)	8 (17)	7 (14.9)	6 (18.8)	7 (35)	2 (18.2)	3 (33.3)
(4)	32 (39.5)	13 (27.6)	9 (19.1)	8 (25)	5 (25)	4 (36.4)	4 (44.4)
(5) = extremely effective	16 (19.8)	10 (21.2)	9 (19.1)	7 (21.9)	3 (15)	2 (18.2)	1 (11.1)

Table 13: *Perceived effectiveness of respondents in coping with violent incidents*

As indicated in Table 13, there was a strong tendency amongst RANs to rate their coping skills as effective. Property damage and physical violence were exceptions to this. However, in all types of violence there were significant numbers of RANs who believed their coping skills were ineffective.

Coping strategies varied markedly, however the most common coping strategies are described below with examples of typical responses in italics.

The most common coping strategy was to **call the police or security police**. This strategy was used as a last resort:

...isolated myself from the incident by locking myself inside health centre and phoned Police.

Last resort in verbal abuse situations that look like getting very ugly - police.

as a threat:

...suggested if it happened again I would call the police.

or as a means of avoiding having to deal with the problem:

....reported incident to police and let them handle it....

Walked away from the situation, told police.

Remain calm (outside) enlist aid of Police

Talk and reason with the client or their family. This strategy was most frequently used as a way of trying to stop the violence:

I enlist aid of police or relatives to stop the damage.

I try to get them to desist by talking.

Called out to speak to perpetrator and calm him down.

Try to talk way out of situation.

Called families in to separate assailants and take them home.

or as a way of trying to prevent future incidents:

Families agreed to meet next day and sort things out.

...families were called to a community council meeting.

Consult withfamily and let them resolve the problem which they do quite well.

Attempting to ignore the behaviour:

I tried to ignore the words.....

Ignored the abuse.

Treated the offender as usual and didn't comment on the incident.

Button my lips and pray a lot!

Withdrawing/walking away from the situation:

Walked away from situation....

...leave community for a few hours - go bush.

I backed off.

...walked away from it.

Talking to the community/community council members:

...consult with community elders

...let other community people handle the aggressor their own way.

...enlist support of community to prevent recurrence.

...rang up chairman at 3 am.

...went to the community council and expressed my feelings.

Request counsellor present for next consultation.

Attempting to calm the perpetrator/situation:

Tried to stay cool and rational.

Remained calm and together.

Kept my cool.

...responded quietly.

...calm behaviour (even if not feeling calm).

There was a tendency for those respondents who wanted to learn more effective strategies for dealing with violence to rate their effectiveness in handling the different types of violence lower than those who believed they did not need to learn more effective strategies. Nevertheless, even those respondents who rated their coping effectiveness as high believed they needed to learn more effective strategies for dealing with violence. Interestingly, in the case of sexual harassment, those who did not want to learn more were least likely to have experienced sexual harassment on duty (chi-square = 9.976, df = 1, p = .01).

4.1.6 Personal safety

A significant number of respondents feared for their personal safety whilst on duty (24.2%), whilst off duty (25%) and whilst on call (33%). Of these, there was a trend indicating that those respondents who had experienced violence were more likely to fear for their personal safety. Table 14 illustrates this finding.

Type of violence experienced	Have experienced violence and are fearful. Frequency(%)	Have not experienced violence and are fearful. Frequency(%)
Verbal aggression and obscene	29 (93.5%)	2 (6.4%)
Property damage	20 (60.6)	13 (39.3)
Telephone threats	10 (27.7)	26 (72.2)
Stalking	7 (20)	28 (80)
Physical violence	20 (58.8)	14 (41.1)
Sexual harassment	17 (51.5)	16 (48.5)
Sexual abuse	5 (14.7)	29 (85.3)

Table 14: Relationship between experiences of violence and fear for personal safety

The open-ended question “What do *you* believe would help to prevent these incidents from occurring in your remote community? “ was asked in order to ascertain how RANs felt personal safety could be enhanced and future violence prevented. The most common themes identified are discussed below with examples of typical responses.

To ban or regulate alcohol:

Enforcement of the no alcohol law.

Less grog.

No alcohol.

Tighter control at the local hotel to stop selling alcohol when people are drunk.

To educate/develop awareness of the community regarding the safety and role of the RAN:

....ensure the council are aware of trouble makers....

More community development and involvement.

Better understanding of culture and by community people of role of RN.

More understanding by community of staff roles....

Education of the community has helped in that potentially violent people now usually come with escorts (relatives).

To ensure better council/community support for staff in addressing problems:

If the community council would support us when these incidents occur, or try to impress on the community we are entitled to some “space”.

Community condemnation of any threatening or abusive behaviour towards health staff.

Community support that abusive behaviour is unacceptable.....

4.1.7 Reporting of violent incidents and support given by employer after incident

Only 52.8% of respondents indicated that they **always** officially reported incidents of violence. Thirty one per cent indicated they sometimes reported incidents, whilst 5.7% said they never did. The majority (74.4%) reported incidents of violence to the police, whilst only 55.6% reported it to their Director of Nursing and 24.4% to their Regional Health Authority. When asked to explain this reporting behaviour, many of the respondents stated that whether or not they reported the behaviour depended upon the severity and the situation, that is they tended to make their own judgments about this. Table 15 illustrates the pattern of reporting by RANs of violent incidents.

Recipients of official reports of violence	Frequency (%)
Police	67 (74.4%)
Director of nursing	50 (55.6)
Your community council	50 (55.6)
Colleague	40 (44.0)
Regional Health Authority	22 (24.4)
Union	10 (11.1)
Other	16 (17.7)

Table 15: Violence reporting behaviour of RANs

Likert scales were used to assess how supported RANs felt when reporting incidents of violence to their employer, and how confident they felt about reporting further incidents. Table 16 indicates that 39.2% of respondents either disagreed or strongly disagreed with the statement; “*I felt fully supported by my employer when I reported the incident* “ and 32.8% disagreed with the statement; “*As a result of this experience I feel confident about reporting future incidents to my employer.*”

level of agreement with statements	...felt fully supported by employer	...feel confident... reporting future incidents to employer
(1) = strongly disagree	14 (18.9%)	11 (15.1%)
(2)	15 (20.3)	13 (17.8)
(3)	20 (27.0)	20 (27.4)
(4)	13 (17.6)	12 (16.4)
(5) = Strongly agree	12 (16.2)	17 (23.3)

Table 16: Perceived levels of confidence and support received from employer

The most common themes identified from the question “*What support does you employer offer you in such incidences?*” are discussed below with examples of typical comments given.

None/ignores/negligible:

Support not really relevant to the situation as the employer does not understand and does not really want to know the dynamics of the situation.

Very little as minor incidents such as verbal abuse happen all the time.

No support whatever.

Employer remote from work site and unable to understand.

None - they tend to blame me.

They offer to remove me from the community for time out, no other help is offered, requests for liaison with council, fencing etc. is ignored.

Evacuate/ give time out:

Immediate offer to leave community.

I am told I would be flown out immediately - upon request.

Immediate evacuation of myself and my family.....

Do get you out of the community if you can't cope.

Evacuation policies recently developed.

4.1.8 Security

Fifty one per cent of respondents did not have access to a security escort whilst on call. Those who did were less likely to be fearful whilst on call (chi-square = 7.184, d.f.=2, p=.05). However a large number (46%) remained fearful for

their personal safety even when escorts were available. There was a trend indicating that those respondents without access to a security escort were more likely to experience violence. This trend was significant for verbal aggression and obscene behaviour on call (chi-square = 7.061, d.f.= 2, p=.05), physical violence on duty (chi-square = 7.266, d.f. = 2 p=.05) and on call (chi-square = 7.445, d.f.=2, p=.05), and sexual harassment on duty (chi-square = 8.439, d.f.=2, p=.05) and off duty (chi-square = 6.305, d.f.=2, p=.05). Nevertheless, 40% of those who experienced physical violence had access to security escorts and 50% of those who experienced harassment also had access to security escorts.

Table 17 illustrates the level of violence experienced by RANs living in differing types of accommodation.

Type of violence experienced	Nurses' quarters/ government accommodation	Community provided accommodation	Own accommodation	Other
Verbal aggression & obscene behaviour	38 (57.6%)	15 (22.7%)	10 (15.2%)	3 (4.5%)
Physical violence	24 (60)	11 (27.5)	3 (7.5)	2 (5)
Property damage	25 (59.5)	12 (28.6)	4 (9.5)	1 (2.4)
Telephone threats	8 (53.3)	4 (26.7)	2 (13.3)	1 (6.7)
Stalking	5 (62.5)	1 (12.5)	1 (12.5)	1 (12.5)
Physical violence	24 (60)	11 (27.5)	3 (7.5)	2 (5)
Sexual harassment	16 (61.5)	5 (19.2)	3 (11.5)	2 (7.7)
Sexual abuse	7 (77.8)	1 (11.1)	0 (0)	1 (11.1)

Table 17: Experience with violence and accommodation type

The majority of respondents lived alone (63.4%), and most (58.7%) lived in nursing quarters/government provided accommodation. There was a trend indicating that those respondents who lived in their own accommodation were the least likely to experience violence when compared to those living in government or community provided accommodation. 42.5% respondents believed their accommodation security systems were not adequately maintained whilst 35.6% perceived that their work place security systems were not adequately maintained.

Likert scales were utilised to assess how respondents perceived the safety of their security systems. Twenty five per cent of respondents tended to disagree with the statement

“the security at my residence makes me feel safe”

whilst 34.4% tended to disagree with the statement

“the security at work makes me feel safe.”

Table 18 illustrates the responses to these two statements.

Level of agreement with statement	... security at residence makes me feel safe	... security at work makes me feel safe
(1) = strongly disagree	8 (9.1%)	9 (10.3%)
(2)	14 (15.9)	21 (24.1)
(3)	25 (28.4)	17 (19.5)
(4)	24 (27.3)	17 (19.5)
(5) = strongly agree	17 (19.3)	23 (26.4)

Table 18: *Feelings about security systems and feeling safe at home and work*

4.1.9 Description of violent incidents

In Part F question 10 respondents were asked to describe a violent incident that had affected them in the past 6 months. Nearly all the respondents described very serious incidents of violence. The full descriptions are included in Appendix 3. In summary:

- the perpetrators of the violence described in these stories tended to be male, and either a client or his family;
- the most frequent type of violence was verbal abuse, however other types included throwing things, physical attack, property damage, spitting, attempting to strangle, sexual harassment, and gunshot to name only a few;
- the violent incidents described in the stories tended to occur mostly at night;
- alcohol and other drugs were identified as important contributing factors by respondents;
- the location of the violence was most frequently in the clinic or hospital, but the pub/hotel also featured heavily;
- respondents described feeling scared, fearful, threatened, frightened, worried, uneasy, sleepless, unsupported, stressed, helpless, shocked, and insulted during and after the episode they described;

- some of the stories identified factors thought to have contributed to the episode including dissatisfaction with the service provided, unreasonable or illegal requests, mental illness, grieving/sadness, and rioting.

4.2 Interviews

4.2.1 Demographic variables

All four participants were female and experienced RANs. The minimum experience within remote areas was 4 years.

4.2.2 Themes identified

Participants identified violence as prevalent in remote area communities but did not perceive the violence as directed towards themselves;

I've never felt personally threatened even though they were attempting to burn the hospital down.

When you have been there a while, when there is violence all around you even if it is really bad, you know it's not, even if there is fighting around the hospital or something, you know they are not trying to get you.

...violence is in the community and it's from the community level. It's not necessarily in my opinion directed at ... the individual.

Similarly to the results of the questionnaire all participants identified alcohol as a contributing factor towards violence;

...well mostly, not always, but mostly the people that abuse you, or get violent towards you have been grogging.

...violence is always alcohol induced you know.

The necessity of having support whether it be from the community itself, employers or the police was a common theme. The most commonly sought source of support was the police, however attempts to seek police support often failed;

...the police have to go on very long patrols and they are not always available ... and they say to us well if we are not there contact the main guys, police, who you know are 300 kilometres away.

One policeman would not answer the phone or answer the door at night ... and would say in the morning that he hadn't heard us.

Thus, whilst police services were certainly sought for assistance, what seemed to make an impression on these RANs were the times when police assistance was not forthcoming.

Respondents also identified the RAN's family and/or friends as a significant source of support. The employers were not mentioned at all as being of support. In fact, the employer was only seen in a negative light;

There is an extremely poor organisation of a situation where you've got no support, you are left all on your own and that is just unforgivable.

The community itself was seen as supportive, but this support was closely linked to one's acceptance within the community and thus needed to evolve over time;

...it's certainly over the years and just through personal involvement and experiences, my presentation to the community has allowed that trust. that credibility comes back and forth, so it's actually interactive.

The stress induced by long hours, on call and difficulty in planning holidays was very apparent throughout the interview with this theme dominating much of the interview;

I'm doing seven out of fourteen nights on call...You get so exhausted towards the end that you know you are not functioning very well, and if you have a run of nights where you're up every single night and no real break at all.

I've gone thirty six hours on my feet. That places you in a very dangerous situation.

You can even get holidays cancelled at the last minute when you've booked them a year ahead 'cause they can't get anyone to relieve you.

You never know when your days off are going to be and you never get the number you are supposed to have.

The employing of inexperienced relief staff to cover holidays appeared to add to the burden of RANs;

They didn't even have any idea until they go to the place that they were totally on their own and three hundred kilometres from a doctor or the next nearest hospital.

It becomes stressful for you in fact to have relievers than it does not to have relievers.

The researchers attempted to encourage the participants to identify coping strategies they utilised to deal with the violence. However, only one participant was able to identify a personal coping strategy;

I just said I really cannot do anything about this and walked away and gone back into my house or unit or whatever. I can't help you anymore, when it's out of control; I can't help you anymore, come back and see me in the morning.

Whilst others identified coping strategies within a social context

I've been adopted by families and family relationships are very important to Aborigine people.

The strategies that we should be looking at developing are how to help that community overcome those issues of violence.

The issues of cultural differences were highlighted in the teleconference particularly in relation to Aboriginal and Torres Strait Islander communities. One participant expressed the presumptions of entering a different culture as:

A lot of people have this huge keenness to travel so they'll do everything, they'll digest how to talk French and what to do. And yet we come to these communities, do we start to research what are the languages of those areas, what are some of the key phrases, what are the things that will get us into the community?

Difficulties in communication were perceived as problematic:

What we miss here are a lot of non-verbal cues which would save our skins a lot more I think.

An interesting phenomena that arose at the end of the teleconference was that each participant expressed gratitude at being allowed to communicate or network with other RANs:

I just want to say how good I feel just having had the opportunity to listen to a few other people from different locations in this kind of forum..And I would certainly welcome opportunities like that in the future .

I agree ... this is my first experience in teleconferencing ... I hope we do it again sometime.

I think it is important for nurses to have a network, however they arrange that.

5. DISCUSSION

5.1 Research methodology

The use of a triangulation research method in this study was an apt one. Empirical data gained from the questionnaire provided clear evidence on personal safety issues. The interpretive data from the open ended questions and teleconference provided the researchers with an avenue for exploring these issues.

5.2 Sample

The results indicate that a majority of RANs are mature women aged in their 30s and 40s, who are well qualified and hold at least two nursing certificates (general and midwifery). Most are well educated (23.5% of RANs hold a degree in nursing) and 77.6% have worked in remote areas for two years or more.

5.3 Level and perception of violence

The level of violence experienced by these nurses is substantial. Almost all of the respondents had experienced episodes of violence within the previous 12 months. Verbal abuse and obscene behaviour were the most commonly experienced types of violence with the majority of RANs experiencing it both on and off duty, and on call. Property damage and physical violence were the next most commonly experienced forms of violence, again whilst on and off duty and when on call. Twenty four hour on call was an employment requirement for 82% of respondents. Those required to be on call 24 hours experienced episodes of violence more frequently. Those RANs living in their own accommodation were significantly less likely to experience all types of violence. As the questionnaire did not identify marital status it is not known if nurses living in their own accommodation were more likely to be married or in a relationship. Anecdotal evidence and teleconference data suggests that this is the case, and if this is so, marital status may be a relevant factor influencing the level of violence.

There was a tendency for respondents, except in the case of physical violence, to perceive both the frequency and severity of their experience with violence as low. Only a very few RANs rated the severity and frequency of violent incidents as high, and yet given the evidence from the descriptions, one would

have expected this number to be higher. Likewise, within the teleconference, participants willingly admitted that violence, although prevalent within their communities, did not affect them particularly. However they were well able to relate stories of violence that had been directed towards other RANs, particularly inexperienced or relieving RANs. Moreover, the participants within the teleconference perceived violence from a broader context, not personally directed at themselves, but within a social context and thus belonging to the community.

On face value this could be interpreted as saying violence is not perceived as a major problem by RANs. However, this would contradict both the anecdotal evidence and the descriptions the respondents have given of a violent incident occurring within the last 6 months. As can be seen in Appendix 3, descriptions of violent incidents are horrific, not only because of the severity and type of violence described, but also because they were recent events. In other words, these descriptions were not 'one off' experiences within the career of a RAN, but were descriptions of incidences occurring to respondents in very recent times.

Possible explanations for the tendency to rate both frequency and severity of violent incidences as low despite contradictory evidence, may lie in the concept of 'context of silence' as discussed in section 2.2.1. The 'context of silence' is a powerful construct when researching violence in communities. For reasons outlined in previous discussions, it is important that RANs both perceive themselves, and be perceived by others as maintaining control of the situation. By rating the severity and frequency as low, they are reassuring themselves and others that this is the case. Furthermore, many RANs in remote communities are a minority group. This may place pressure upon these RANs to conform to the norms of the majority culture in order to gain some level of acceptance. The 'context of silence' surrounding the issue of violence may be one of the norms they perceive as necessary to accept.

Moreover, as the majority of the respondents were experienced RANs, they had presumably 'lived with violence' for a period of time. As a consequence violence may have become accepted either consciously or unconsciously, as a norm of the culture they have chosen to live and work in. This socialisation process may encourage the RAN to objectify violence, or become 'hardened' to the impact of this violation in order to survive both professionally and personally.

5.4 Perceptions of coping skills

The majority of respondents and participants perceived their coping skills as being effective in violent situations. This phenomenon may be an example of adapting coping strategies. As the majority of respondents and all of the participants in the telephone conference were experienced RANs, it can be assumed that each had developed various coping strategies, or even survival skills in order to cope. Moreover, this perception of coping effectively could be viewed as an example of a defence mechanism; a strategy used unconsciously to decrease anxiety and protect the self by denying or distorting a stressful event or the reaction to the event (Wilson & Kneisl 1992). It is interesting that the perception of coping increased with experience suggesting that the inexperienced RAN may not have developed such coping strategies.

Another possible explanation relates to the concept of cognitive hardiness. This personality trait has been cited as beneficial in buffering the effects of job-related stress. It is composed of the cognitive appraisals of commitment, control and challenge, and influences both the individual's perception of and response to stressful events (Pick and Leiter 1991). This personality trait has been linked to the profession of nursing, particularly with nurses in high stress areas such as intensive care (Maloney & Bartz 1983). Consequently, if transposed to RANs, it could be hypothesised that if RANs perceive that they coped effectively with a violent situation, control is maintained and the stress resulting from the violent incident would be less than if they perceived they had poor coping skills. The maintenance of control is reflected in the words of one telephone conference participant;

I've never felt personally threatened even though they were attempting to burn the hospital down ... it's not necessarily in my opinion directed at the individual

Despite, the majority of RANs claiming that they coped effectively with incidences of violence many of the coping strategies named such as ignoring the situation, hiding or walking away are seemingly ineffective ones.

5.5 Stress and perception of personal safety

The frequency and severity of the violence portrayed in the questionnaire results and telephone conference interviews indicate that RANs are living with frequent threats to their personal safety. Significantly over one third of the respondents indicated that they feared for their personal safety; 51% had no access to a security escort when on call and a large number felt that security was not maintained adequately where they lived and worked. As illustrated in the

following comment, a significant number of the respondents did not feel safe in their work or even in their homes

get real, some of these places are lawless and out of control

Only 26% of respondents felt that security at their place of employment made them feel safe, with only 19% agreeing that security at their accommodation made them feel safe. Issues relating to security had some bearing on the perception of fear. Access to a security escort appeared to do little to allay fear for personal safety, although those respondents who did have access were less likely to be fearful generally than those without. Moreover, although access to security escorts tended to reduce violence, a very large number of RANs continued to experience violence even with escort access. The sense of living with fear unceasingly, without even their home providing a sanctuary away from fear, was clearly evident in the stories. Consequences of this were reflected in the reporting of symptoms of stress such as lack of sleep and a generalised feeling of stress identified by some respondents.

5.6 Role of employer and perception of support

The stress associated with fear was compounded by organisational induced stressors. One participant from the teleconference reported

you get so exhausted towards the end, that you know you are not functioning well .. I've gone thirty six hours on my feet.

And another

It does get extremely weary. You can get holidays cancelled at the last minute when you've booked them a year ahead 'cause they can't get anyone to relieve you

Accompanying organisational induced stressors is the concerning fact that 44.3% of the respondents disagreed with the statement; *"The level of professional support I receive meets my working needs "* and 38.7% disagreed with the statement; *"I felt fully supported by my employer when I reported the incident"*. Apart from offers to evacuate, there was little or no support forthcoming from employers after incidents of violence were reported. Formal debriefing or post-crisis counselling for the victim of violence were virtually non-existent. This is of special concern for RANs who frequently work in isolation, usually know the perpetrator and their family/community well, do not have the opportunity to shift the burden of caring for the individual to another health worker, and do not have access to even informal modes of support. A significant number indicated that as a result of their experiences with their employer they no longer felt confident about reporting future violent incidents to them. This finding might partially explain why so many RANs choose not to report incidents of violence to

Regional Health Authorities, preferring to use the police (although many reported that attempts to seek support from police were often unsuccessful also).

A further concern is the lack of orientation and cultural awareness education the RANs had received. It was surprising that so few nurses were adequately orientated to their communities and that so many felt the orientation and cultural awareness that they received was inadequate. Ignorance of cultural norms and expectations can result in unintentional cultural violence on the part of the RAN toward the community and its members. As one respondent stated:

... a point worth making in the whole debate about violence in the workplace, is that violence of one sort (verbal, attitudinal, cultural) is often met with violence of another type (physical).

The consequences of such paucity of preparation for the role of the RAN, may be reflected in the problems relievers have in coping with remote area nursing, the difficulty RANs have in developing a sense of belongingness to their community, the violence in these communities, and ultimately the high staff turnover.

5.7 Community issues identified within the study

Similarly, the lack of knowledge on the part of the community as to the role of the RAN caused problems. Community perceptions on the role of the RAN were frequently identified as unrealistic. Anger often appeared to be a result of these differing role interpretations. One expectation appeared to be that the RAN was there to serve the community both day and night as needed. If the nurse was unable to fulfil this role/expectation, criticisms and accusations of laziness and slackness sometimes ensued. One respondent felt that *"this was worse than a slap in the face"* as the perception held by the RAN that they are helping the community is often their major impetus for being there. One participant in the teleconference stated

it's certainly over the years and just through personal involvement and experiences ... (that) has allowed that trust, that credibility (that) comes back and forth, so it's actually interactive.

Furthermore without recognition by the community, the RAN is without respect and status, and their personal safety may become even further jeopardised. This is reflected in the relationship between one's sense of belongingness and their experiences of violence, with those respondents who expressed a sense of belongingness to the community in which they worked reporting less fear for their personal safety .

The community context of violence was stressed by the majority of RANs with most prevention strategies suggested focusing on community involvement and

changes. A prominent theme expressed was the role alcohol had in exacerbating violence with many RANs demanding a ban, or tighter control on alcohol consumption in remote communities. Although there were numerous occasions reported where the nurse seeking the support of the community leaders almost always found a satisfactory response and the support required, some RANs felt that there was little support from the community when a violent incident occurred nor active condemnation of violence itself.

Taken together, these amalgam of stressors of living with fear for one's personal safety, accompanied by the lack of opportunities to relieve stress such as time off and support from employers, plus the almost non-existent debriefing services and stress relief, and lack of preparation for the reality of the role cannot but result in an increased potential to experience both physical and emotional problems (Engel & Marsh 1986). Moreover, the almost daily impact of many of these stressors in both their working and private lives is significant, and may further explain the very high staff turnover rates in some remote communities.

6.1 Limitations to the study

There are a number of reasons why it is necessary to be cautious in generalising the findings from this study to all RANs. Firstly, the questionnaires were distributed to CRANA members only. This has the potential to create a sample biased towards those RANs who are more experienced and possibly more politically aware. Furthermore, CRANA members are more likely to be those nurses who have a commitment to staying in remote area nursing, have been in remote area nursing long enough to have heard of CRANA, and who also believe it is in their interests to pay an annual subscription fee to a representative body.

Secondly, the ages of the respondents, and the length of time they have worked in remote communities, indicates that the respondents to this survey and the participants in the teleconference tend to be more experienced RANs. Data collected in December 1992 for the Peninsular and Torres Strait region states that 70% of remote area nurses have been there less than one year, with only 8% being there for more than two years (Brown 1992).

Thirdly, the response rate was much lower than expected for the questionnaire and volunteering for the teleconference. Possible explanations for this low response rate include issues identified in Section 2.1 relating to the 'context of silence' surrounding violence. This context of silence is especially strong for RANs who are living and working in remote, frequently Aboriginal communities, where 'speaking out' on community matters may result in repercussions for the nurse and/or the community. The nature of this research project is potentially controversial, as the violence occurring against remote area nurses may be perceived as racially inspired. This prospect along with its inherent media potential for sensationalism, and consequent negative impact for the communities involved, might explain a reluctance on the part of the RAN to respond to the questionnaire. Moreover, the 'context of silence' may be necessary for some RANs in order to 'forget'. A member of the research team, who has debriefed many of these remote area nurses after violent incidents, discussed with some why they did not complete the questionnaire and received the same reply "I just couldn't. I tried, but I couldn't."

The telephone conference presented an interesting phenomena with all four participants known to one another. This may have further contributed to the 'context of silence' as participants may have feared being perceived by their colleagues as not coping in their communities.

The fact that the respondents to this questionnaire and participants in the teleconference may be more experienced than RANs in general, could mean that the findings from this survey reflect issues peculiar to the more experienced cohort, with the reality for less experienced RANs being very different. However, given the high staff turn over rate for this younger, less experienced cohort (National Aboriginal Health Strategy 1989; National Rural Health Strategy 1993; Kreger 1991; Gray and Buckley 1993), we suspect that the problems relating to safety for this inexperienced group may be even greater than the findings suggest for this study.

No conclusions could be drawn about ATSIHWs as the number of ATSIHWs who responded to the questionnaire was very low (n=4 or 4% of sample). Although cognizant of the fact that a small number of ATSIHWs did respond to the questionnaire the authors chose to identify the population as RANs only, as the number of ATSIHW respondents is in no way representative of the total number of ATSIHWs in remote communities in Australia but is in fact reflective of the initial distribution of the questionnaire

7 CONCLUSION

This research gained its impetus from some of the researchers' own experiences as RANs and more recently their experiences associated with revisiting remote area communities and speaking to RANs working and living within these communities. The purpose was to gather data relating to the frequency and severity of violent incidents experienced by RANs, and to explore perceptions related to coping skills and to determine to what extent the RANs' experiences with violence are stressors in their work.

The results were as expected; violence towards RANs is extreme. This study found that the experience of violence by remote area nurses both in their place of work, and in their private lives is severe and is often handled badly by employers, the community, and by remote area nurses themselves. Sadly, and of great concern, is the lack of support from colleagues and employees once a violent incident occurs.

The literature on violence against nurses and findings from this study, identify a context of silence that ensures consistent underreporting, and downplaying of the severity of the problem. The context of silence that surrounds this issue needs to be overcome so that appropriate policy, post trauma procedures, and preventative education campaigns can be implemented.

Violence against RANs is a fundamental violation of human rights, and like other forms of violence should be perceived as a criminal matter which is open to scrutiny and intervention. Currently "the employer's responsibility for the occupational health and safety of RANs appears poorly understood or enforced" (Kreger 1991 p.20).

This research team believes that acknowledgement of RANs as victims of a blame-free traumatic event is of critical importance in the development of policies and intervention programs to address the issue of personal safety of remote area nurses. We make the following recommendations.

8 RECOMMENDATIONS

- 1.** That the Federal Government, each State and Territory government and employing bodies acknowledge that Remote Area Nurses suffer substantial risk of violence both threatened and real.
- 2.** That Federal, State and Territory governments and employing bodies as a matter of urgency:
 - acknowledge that the current situation is unacceptable;
 - develop formal and informal mechanisms to provide:
 - appropriate and adequate 24 hour debriefing and post-trauma services for RANs and other health staff (these may be required to be independent of the employing body);
 - RANs with appropriate support including time off, adequate relief and time out of the community;
 - establish regular support networks for all health professionals working in geographical and professional isolation;
 - orientate all administrators of remote area health care to the occupational health and safety needs of remote area health staff;
 - provide adequate and safe housing, workplace, maintenance and security systems.
- 3.** That the Federal Government, State and Territory governments and employing bodies make a firm commitment to:
 - develop policy in conjunction with RANs, employers and remote area consumers to protect the occupational health and safety needs of RANs;
 - provide funding to develop geographically and culturally appropriate orientation programs which are compulsory for all RANs prior to employment in remote areas. The program should include components on:
 - cross cultural awareness;
 - crisis intervention techniques;
 - violence management and prevention;
 - maintenance of support networks in the community;
 - overall structure of the health service and its role in the community;
 - stress management strategies;and that this orientation program be developed in consultation with RANs, employers and remote area consumers;
 - providing tangible support for community councils and relevant government authorities in enforcing existing laws in the sale and distribution of alcohol in all remote communities.

4. That regional tertiary institutions, in particular, and all institutions which provide distance education for health professionals include relevant subjects in programs which explore issues of primary health care, cross cultural service provision, violence management and prevention, the application of appropriate counselling and crisis intervention techniques.
- 5 . That research be instigated exploring issues of safety for Aboriginal and Torres Strait Islander Health Workers.

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APPENDICES

Appendix 1: Plain English definitions of types of violence identified

•Verbal Aggression and Obscene Behaviour:

Definition: A patient swears or uses obscene behaviours which could be verbal or non-verbal with the purpose of offending you, your family, other clients or health workers.

•Property Damage

Definition: A patient purposely damages or attempts to damage the property belonging to you, your family, other clients or health workers.

•Telephone Threats

Definition: A patient or member of the community purposely uses the telephone to threaten you, your family, other clients or health workers.

•Stalking

Definition: A patient or somebody else purposely stalks or follows you, your family, other clients or health workers to or from home or place of work, which you feel is intended to be harmful or threatening.

•Physical Violence

Definition: A client or somebody else physically attacks you, your family, other clients or health workers for example by punching, pushing, spitting, throwing things.

•Sexual Harassment

Definition: Any form of sexual propositions or unwelcome sexual attention that you, your family, other clients or health workers find intimidating, humiliating or offensive such as jokes and remarks with sexual overtones patting, pinching, flashing or touching in a sexual way.

•Sexual Abuse

Definition: Any forced sexual act, rape or indecent assault that occurs without your, your family, other clients or health workers full consent.

Appendix 2: Questionnaire

Confidential

**Questionnaire For Research on
Enhancing Personal Safety**

Please read each question carefully and indicate your response by marking the appropriate box or by writing comments in the space provided.

PART A INFORMATION ABOUT YOU

1. Your current age is:

- ☐ less than 20 years
- ☐ 20-29 years
- ☐ 30-39 years
- ☐ 40-49 years
- ☐ over 50 years

2. Your gender is:

- ☐ female
- ☐ male

3. Your Regional Health Authority employer is:

.....
.....
.....

4. Your **current** position is:

- ☐ Aboriginal or Torres Strait Islander Health Worker (ATSIHW)
- ☐ Registered Nurse
- ☐ Enrolled Nurse
- ☐ Assistant in Nursing
- ☐ Other (specify).....

5. Please indicate your **current** qualifications:

- ☐ General Nurse Certificate
- ☐ Certificate in Aboriginal and Torres Strait Islander Primary Health Care
- ☐ Enrolled Nurse Certificate
- ☐ Registered Midwife
- ☐ Child Health Certificate
- ☐ Psychiatric Nursing Certificate
- ☐ Degree in Nursing
- ☐ Other Qualifications (specify).....

PART B ABOUT YOUR PLACE OF EMPLOYMENT

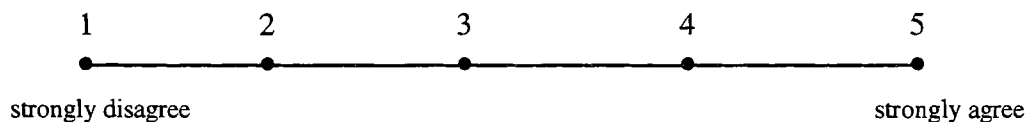
1. What is the population of the community in which you work?
☐ less than 500 people
☐ 501 - 1200 people
☐ 1201 - 3000 people
☐ more than 3000 people
2. How long have you been employed in your current community?
☐ one month or less
☐ 2-6 months
☐ 7-12 months
☐ 13-23 months
☐ 2 - 5 years
☐ more than 5 years
3. Your **total** length of employment in remote area communities is:
☐ one month or less
☐ 2-6 months
☐ 7-12 months
☐ 13-23 months
☐ 2 - 5 years
☐ more than 5 years
4. How many other registered nurses do you work with in your community?
(Please write the number in the box)
5. How many other health workers do you work with in your community?
(Please write the number in the box)
6. Are you currently fully staffed in your community?
☐ yes ☐ no
7. Does your employment require you to work on a 24 hour on-call basis?
☐ yes ☐ no
8. Is there usually a doctor based in your community?
☐ yes ☐ no

9. How often are you visited by the Royal Flying Doctor Service or other doctor services?

- ☐ Never
☐ Emergencies only
☐ Twice per week
☐ Weekly
☐ Fortnightly
☐ Monthly
☐ Other (specify).....

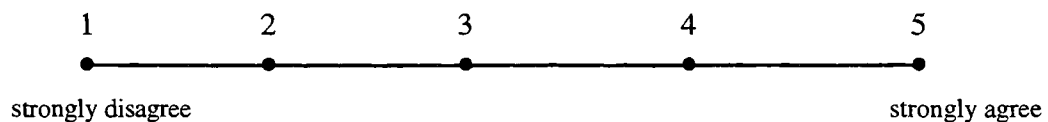
10. Circle one option on the scale provided to indicate your agreement or disagreement to the following statement.

"The level of professional support I receive meets my working needs."



- 11.

"I feel a true sense of belongingness to the community in which I work"



PART C ABOUT ORIENTATION AND INSERVICE PROGRAMS UNDERTAKEN AS PART OF YOUR CURRENT WORK

1. Did you undertake an orientation program prior to starting work in your present position?

☐ yes

☐ no

2. Have you undertaken any form of orientation or inservice program since that time?

☐ yes

☐ no

STOP! If you answered 'no' to questions 1 and 2 please go to Part D

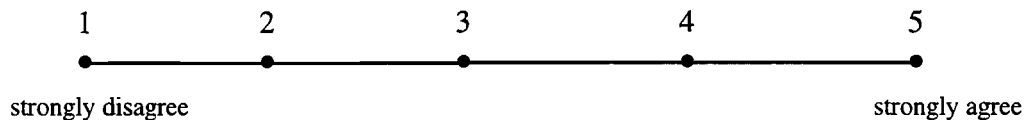
3. Did you receive any cross-cultural information in your orientation or inservice programs?

☐ yes

☐ no

4. Circle one option on the scale provided to indicate your agreement or disagreement to the following statement.

"The cross cultural information I received adequately prepared me for the reality of my current work position."



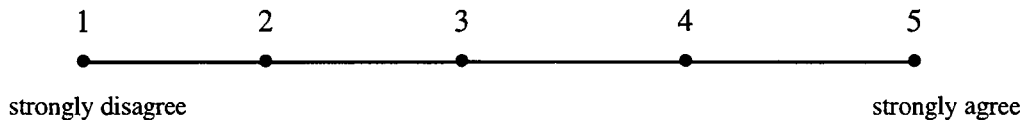
5. Were you given any information in these programs which related to the issue of personal safety in remote area communities?

☐ yes

☐ no

Circle one option on the scale provided to indicate your agreement or disagreement to the following statement.

"The information on personal safety adequately prepared me for the reality of my work."



PART D ABOUT YOUR EXPERIENCE WITH VIOLENT INCIDENTS

In this section the following issues will be examined:

- Verbal Aggression
- Obscene or Offensive Behaviour
- Property Damage
- Telephone Threats
- Stalking
- Physical Violence
- Sexual Harassment
- Sexual Abuse.

The questions on the following pages seek information about your personal experience in the last 12 months related to each violent incident. To help you answer, a definition of each violent incident is provided.

1. Violent Incident - Verbal Aggression and Obscene Behaviour

Definition: A patient swears or uses obscene behaviours which could be verbal or non-verbal with the purpose of offending you, your family, other clients or health workers.

- (a) In the past 12 months have **you** experienced or witnessed verbal aggression while working in a remote area community?

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

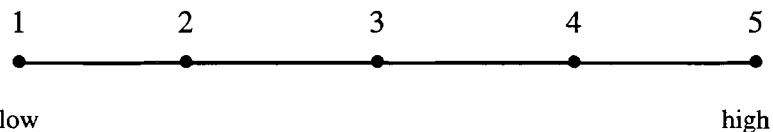
☐ yes

☐ no

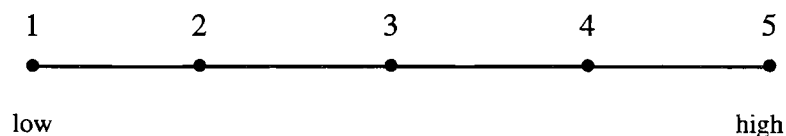
STOP! If you answered 'no' to all of the above please go to Question 2

- (b) How would **you** rate the frequency (how often) and severity (how bad) of **your** experiences with verbal aggression on the scales provided below.

Frequency
(how often)



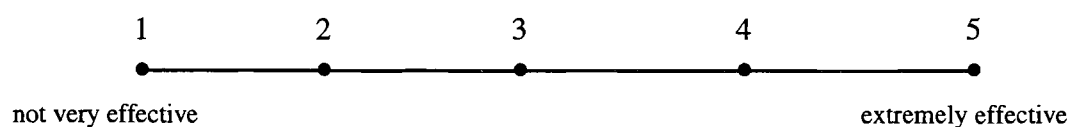
Severity
(how bad)



- (c) Please describe the way **you** coped with instances of verbal aggression and indicate on the scale how effective **you** thought you were in handling the situation.

.....
.....
.....
.....

Effectiveness



2. Violent Incident - Property Damage

Definition: A patient purposely damages or attempts to damage the property belonging to you, your family, other clients or health workers.

- (a) In the past 12 months have **you** experienced or witnessed property damage while working in a remote area community?

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

☐ yes

☐ no

STOP! If you answered 'no' to all of the above please go to Question 3

- (b) How would **you** rate the frequency (how often) and severity (how bad) of **your** experiences with property damage on the scales provided below.

Frequency
(how often)

1	2	3	4	5
•	•	•	•	•
low				high

Severity
(how bad)

1	2	3	4	5
•	•	•	•	•
low				high

- (c) Please describe the way **you** coped with instances of property damage and indicate on the scale how effective **you** thought you were in handling the situation.

.....
.....
.....
.....

Effectiveness

1	2	3	4	5
•	•	•	•	•
not very effective				extremely effective

3. Violent Incident - Telephone Threats

Definition: A patient or member of the community purposely uses the telephone to threaten you, your family, other clients or health workers.

- (a) In the past 12 months have **you** ever experienced or witnessed telephone threats while working in a remote area community?

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

☐ yes

☐ no

STOP! If you answered 'no' to all of the above please go to Question 4

- (b) How would **you** rate the frequency (how often) and severity (how bad) of **your** experiences with telephone threats on the scales provided below.

Frequency
(how often)

1 2 3 4 5

low high

Severity
(how bad)

1 2 3 4 5

low high

- (c) Please describe the way **you** coped with instances of telephone threats and indicate on the scale how effective **you** thought you were in handling the situation.

.....

.....

.....

.....

Effectiveness

1 2 3 4 5

not very effective extremely effective

4. Violent Incident - Stalking

Definitions: A patient or somebody else purposely stalks or follows you, your family, other clients or health workers to or from home or place of work, which you feel is intended to be harmful or threatening.

- (a) In the past 12 months have **you** experienced or witnessed stalking while working in a remote area community?

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

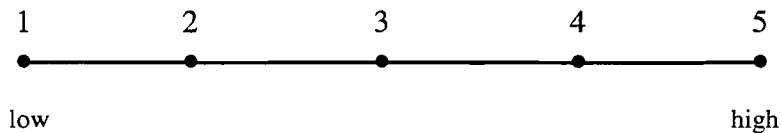
☐ yes

☐ no

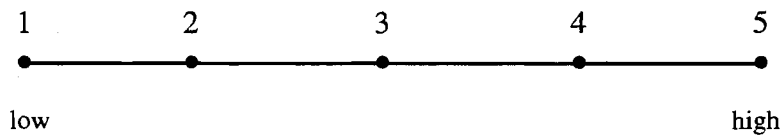
STOP! If you answered 'no' to all of the above please go to Question 5

- (b) How would you rate the frequency (how often) and severity (how bad) of **your** experiences with stalking on the scales provided below.

Frequency
(how often)



Severity
(how bad)



- (c) Please describe the way **you** coped with instances of stalking and indicate on the scale how effective **you** thought you were in handling the situation.

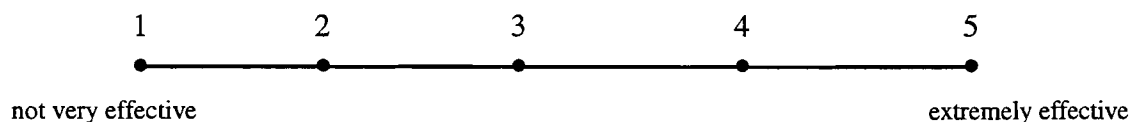
.....

.....

.....

.....

Effectiveness



5. Violent Incident - Physical Violence

Definition: A client or somebody else physically attacks you, your family, other clients or health workers for example by punching, pushing, spitting, throwing things.

- (a) In the past 12 months have **you** ever experienced or witnessed physical violence while working in a remote area community?

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

☐ yes

☐ no

STOP! If you answered 'no' to all of the above please go to Question 6

- (b) How would you rate the frequency (how often) and severity (how bad) of **your** experiences with physical violence on the scales provided below.

Frequency (how often)	1	2	3	4	5
	●	●	●	●	●
	low		high		
Severity (how bad)	1	2	3	4	5
	●	●	●	●	●
	low		high		

- (c) Please describe the way **you** coped with instances of physical violence and indicate on the scale how effective **you** thought you were in handling the situation.

.....

.....

.....

.....

Effectiveness

1	2	3	4	5
●	●	●	●	●
not very effective		extremely effective		

6. Violent Incident - Sexual Harassment

Definition: Any form of sexual propositions or unwelcome sexual attention that you, your family, other clients or health workers find intimidating, humiliating or offensive such as jokes and remarks with sexual overtones patting, pinching, flashing or touching in a sexual way.

- (a) In the past 12 months have **you** experienced or witnessed sexual harassment while working in a remote area community?

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

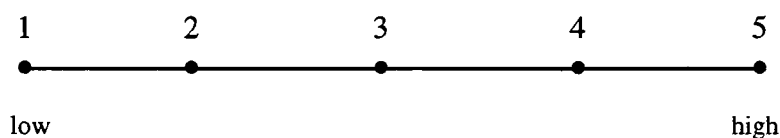
☐ yes

☐ no

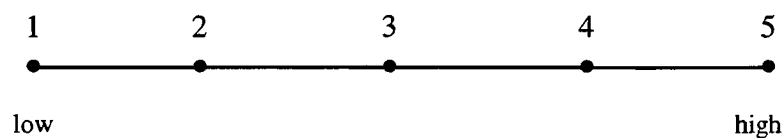
STOP! If you answered 'no' to all of the above please go to Question 7

- (b) How would **you** rate the frequency (how often) and severity (how bad) of **your** experiences with sexual harassment on the scales provided below.

Frequency
(how often)



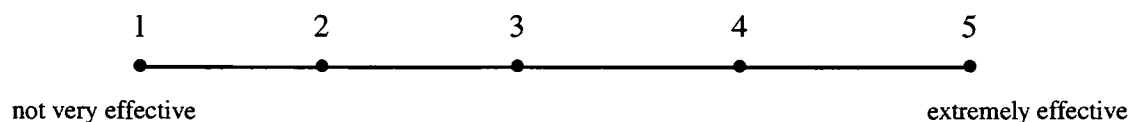
Severity
(how bad)



- (c) Please describe the way **you** coped with instances of sexual harassment and indicate on the scale how effective **you** thought you were in handling the situation.

.....

Effectiveness



7. Violent Incident - Sexual Abuse

Definition: Any forced sexual act, rape or indecent assault that occurs without your, your family, other clients or health workers full consent.

- (a) In the past 12 months have **you** experienced or witnessed sexual abuse while working in a remote area community?

On duty
☐ yes
☐ no

Off-duty
☐ yes
☐ no

On Call
☐ yes
☐ no

STOP! If you answered 'no' to all of the above please go to Part E

- (b) How would **you** rate the frequency (how often) and severity (how bad) of **your** experiences with sexual abuse on the scales provided below.

Frequency
(how often)

1 2 3 4 5

low high

Severity
(how bad)

1 2 3 4 5

low high

- (c) Please describe the way **you** coped with instances of sexual abuse and indicate on the scale how effective **you** thought you were in handling the situation.

.....
.....
.....
.....

Effectiveness

1 2 3 4 5

not very effective extremely effective

PART E ABOUT YOUR PERSONAL SAFETY

1. Do you now fear for your personal safety whilst....

On duty

☐ yes

☐ no

Off-duty

☐ yes

☐ no

On Call

☐ yes

☐ no

2. Please describe any other threat to **your** personal safety that has not been covered in the incidents described in Part D .

.....

.....

.....

.....

.....

3. Do you believe **you** need to learn more about effective strategies for dealing with these kinds of incidents?

☐ yes

☐ no

4. What do **you** believe would help to prevent these incidents from occurring in your remote area communities?

Please describe

.....

.....

5. If incidents of violence occur, do you officially report it?

☐ yes

☐ no

☐ sometimes

☐ not applicable

Please explain

6. Who do you officially report the incidents of violence to?
(Mark as many as relevant)

☐ Director of Nursing

☐ The police

☐ The regional health authority

☐ Your community council

☐ A colleague

☐ The Union

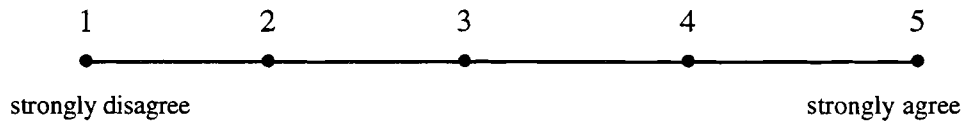
☐ Other (specify).....

7. What support does your employer offer you in such incidences?

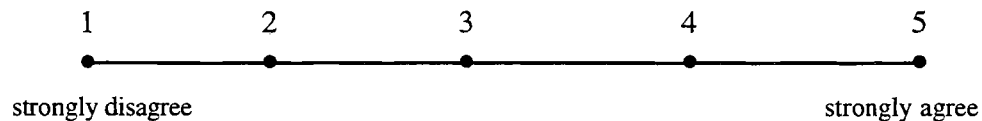
.....
.....
.....
.....

8. Please indicate how you feel about the following statements by marking one option on the scales below.

- (a) **"I felt fully supported by my employer when I reported the incident."**



- (b) **"As a result of this experience I feel confident about reporting future incidents to my employer."**



PART F ABOUT SECURITY

1. Do you have access to a security escort when you are on call?

☐ yes ☐ no ☐ not applicable

2. How often do you use this security escort when on call?

☐ always
☐ sometimes
☐ not applicable

Please explain

3. What kind of accommodation do you live in?
(Mark as many as relevant)

☐ Nursing quarters/Government accommodation
☐ Community provided accommodation
☐ Own accommodation
☐ Other (specify)

4. Do you share your accommodation?

☐ yes ☐ no

5. What kind of security do you have in your accommodation?
(Mark as many as relevant)

☐ Telephone
☐ Security fence
☐ Outdoor lighting
☐ Deadbolt locks
☐ Simple key locks
☐ Security alarm system
☐ Security bars on windows
☐ Intercom system to exterior
☐ Peep hole in door
☐ Other (specify).....

6. Is the security maintained adequately at your accommodation?

- ☐ yes
☐ no
☐ If no, please explain
.....
.....

7. What kind of security system do you have at work?
(Mark as many as relevant)

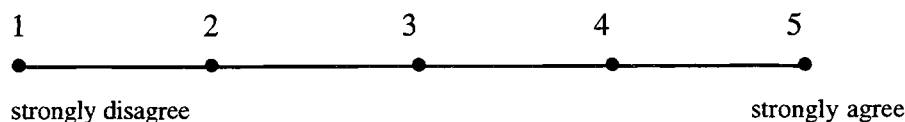
- ☐ Telephone
☐ Security fence
☐ Outdoor lighting
☐ Deadbolt locks
☐ Simple key locks
☐ Security alarm system
☐ Security bars on windows
☐ Intercom system to exterior
☐ Peep hole in door
☐ Other (specify)

8. Is the security maintained adequately at your work?

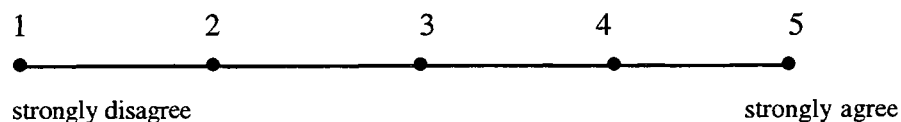
- ☐ yes
☐ no
If no, please explain.....

9. Please indicate how you feel about the following statements by marking one option on the scales below.

(a) **"The security at my residence makes me feel safe."**



(b) **"The security at work makes me feel safe."**



10. We would greatly value your description about an incident that has affected you in the last 6 months. In the space provided please describe the incident, without identifying the community or individuals involved.

Please consider joining us in the upcoming **teleconference** where there will be an opportunity for you to relay your story and exchange experiences with other people. The **consent form** for the teleconference has been included as well as a list of possible dates for the teleconferences to occur. If you have more questions about participating in the teleconference, you are invited to ring the toll free number to CRANA in Cairns and speak to Janie Smith on: 008-805 391 or Trish Robins in Rockhampton on: 079-309 244.

Thank you for your patience and valuable contributions in completing the questionnaire.

We remind you that all information in this questionnaire should be submitted in the envelope provided and will be treated confidentially.

Appendix 3: Question 10

QUESTION 10

1 – I have had incidents in the past that have affected me but none in the past 6 months. I would be very reluctant to return to a community where there was alcohol abuse.

2 – While reversing out of our driveway to attend a call out a man smashed the windscreen of our car with his fists and threatened to kill us.

5 – Patient had been stabbed in the heart and was critical. During time up to doctor's arrival (2+ hours) riot between family of patient and assailant. Threatened to burn down hospital if patient died. Damaged exterior. One brother of patient very verbally threatened inside, tried to interfere with treatment – patient required continual resus till arrival of Dr and had 2 drips going – brother was constantly calmed by another brother. It took doctor over an hour to stabilise patient, during which riot continued. Police came down from city to assist local policeman who was new and very frightened. It all calmed down when patient left. The brother came up to apologise next day. The patient survived after massive surgery in Brisbane.

8 – On call in community. 1900 hrs woman came to my Donga and asked for chronic medications for her child. Run out, been away all day. I said I would go to clinic and get her the medication (for fitting) but suggested she should come in clinic hours to pick up on-going medications. She informed me no-one had ever told her that before. Went to clinic and dispensed medications. Next day I checked with ... and was told she is always told to come in clinic hours – but never does. 2 days later, at work, I received a phone call from this lady, telling me she had the deputy chairman there with her ... and he and she were both unhappy with my treatment of her 2 nights previous, and the fact that I had mentioned it to (acting DON) (don't know how she knew that). She became quite aggressive and when she suggested putting deputy chairman on phone I suggested a face to face discussion. Late in day we met at clinic, with the senior ab health worker in attendance. Deputy chairman was very surly – said he didn't want to be down here sorting our new RNs all the time. – Mother says "watch it" or you will be "out" – and why was I there – just to make money etc. I kept repeating about call outs being for emergencies etc – and explained why I had discussed the incident with acting DON (she was off on leave this particular day). They left and I was quite upset – but that is life on a community. 2 hours later this lady rang me again and apologised on both her and her partners behalf. So we shook hands over the phone. This did not all together make up for the insults, threats etc I received – and client continues to come after hours for this child's medications.

15 – Whilst undertaking an RFDS evacuation the health vehicle was attempted to be stolen whilst I was in the car. This occurred around midnight.

17 – During early hours of morning people throwing rocks, onto roof and shouting. Windows smashed. Entry to kitchen and food stolen.

20 – I was standing in the main treatment room, on the side opposite the windows, when I heard what I at first thought was a gunshot. Then I heard the sound of glass crashing. Someone outside continued to throw things until the three big front windows were broken and the room had glass from one side to other (I was well out by now). The glass flew with such force that the wall

opposite the window was marked by glass fragments. Later I discovered a minor cut to my leg which I had not felt initially. I was shocked by the incident but even worse than that I could imagine what would have happened had the incident occurred at a busy time when there could have been up to eight people in the room, some sitting very close to the windows. The young man involved had only a few weeks before roamed the town with a rifle with a 60 shot magazine. He had shot at/around the hospital on his way past. The police chose not to fly him out after the shooting incident as the magistrate was soon due to come and it saved them paperwork and hassle to leave him in town. The potential for harm from this incident was enormous. I completed an incident form but have heard no more. (A diagram is on this questionnaire)

22 – I was called out by a drunken man at 3am. Walking through the village with patient and my husband to the clinic we were approached in a menacing manner by 3 young men. Upon request they stepped aside – however they later entered the clinic while the patient was receiving treatment – and when asked to leave, one man slapped my husband's face. The community council disciplined the three young men.

27 – Called out late at night to a male patient – while treating male patient – female patient arrive having been speared in leg by male de-facto. While both patients in clinic – de-facto outside – calling out rattling windows and doors acting in violent manner – trying to get into building – de-facto aimed with rifle – has H/O violence this went on for about 1/2 hour before state police called. It took police approx 2 hrs to arrive from "town" – in the mean while both patients were treated and kept at clinic till police arrived for their own protection – de-facto left clinic area after approx 3/4 hrs – When state police arrived he was removed from community – both patients were then transferred to hospital for further treatment and for their safety.

29 – ... patient (once request denied) began verbally abusing me and acting in a manner that the argument may deteriorate into a "physical" situation. Asked client to leave, he refused then threatened to smash up the clinic and run me out of town ... I removed myself from the room and rang the police, which I told him I would do. He left. Snr AHW stayed with me and supported me during argument.

30 – On call – saw a youth in clinic who had been "beaten-up" by a gang of boys in the community. Client had badly lacerated lip (hanging off). Whilst on the phone to a MO – he stormed out of the clinic, tossing furniture on the way out. Obviously affected by a mixture of alcohol and "gunja". Visited clients residence to perform treatments. He fronted me – inches from my face, spat blood onto my face, pushed and shoved me, swore at me (f'in c—nt, mother—fu—er, white c—t, lesbian etc, etc) Then proceeded to smear his blood over my face and clothing. This was witnessed by many community members who had surrounded the house (event occurred in garden). I was rescued from the situation by a community elder who guided me away from him.

34 – Verbal abuse on telephone re:asking patient to phone hospital prior to going out to station where men drink. Ambulance men went from town and advised made right decision. No police in town to take with me. Reported incident to hospital. Sleepless night worrying about making "correct decision".

35 – This is a "dry" community with by-laws and wardens. The community are normally friendly and polite. Alcohol was brought in and a young teenage girl presented to the clinic after hours and after dark. No illness or reason given

– she launched into an obscene abusive tirade against me complete with threats to "get" me later. There were 6 or 7 of her friends present who found this very amusing and egged her on. I spoke briefly, quietly, but firmly and withdrew from the encounter. Rocks were thrown at the clinic and adjoined flat but I did not interfere. Next day the young teenager came to apologise and acknowledged that the incident broke the by-laws and she could have been fined \$100 or imprisoned for 3 months. The client accepted this as a warning. Incident documented in client's records and notified to Nurse Manager. No response from health management. Incident discussed with community chairperson who approved course of action.

37 – A young male, in police custody, had started fitting in the cells. He was a petrol sniffer and was actually being released from the cells when it occurred. The police obviously couldn't let him go in that condition, no family was available and he was not in his home town. After I assessed him and spoke to the RFDS it was decided that he be transported by ambulance to the nearest hospital 234km away. He was unable to take oral valium so I had given him 10mg IV valium which seemed to have a good effect. He was put in the ambulance and I was in the back with him and 2 St John volunteers were in the front. No police escort was needed as he was calm and officially released from custody. 5km away from our town the patient turned aggressive, got out of his stretcher restraints and we had to pull over to the side of the road. (This was about 2am). He claimed he needed to go to the toilet so we let him out of the ambulance but after 5 minutes he still wouldn't go to the toilet. We then tried to get him back in the ambulance where he got physically and verbally aggressive – He bit, scratched, kicked, punched and spat at us. Literally we had to sit on him, turn the ambulance around and head back to the police station where he was put back in the cells. As soon as he saw the police he acted quietly and calmly. He was given oral valium and observed overnight in the cells. Just as a matter of note – we didn't air evacuate him because of his condition and it was a good thing too as a disaster could have happened if he'd turned violent whilst in the air. We also couldn't keep him at the clinic as it has not suitable facilities for an overnight stay. Regardless of how strong we were (the boy was smaller than me) petrol sniffers seem to have the strength of 5 people. It was a very frightening experience for me and one I will never forget. You don't realise how vulnerable you are in remote areas and in the confines of a speeding ambulance with a violent person you can be really afraid for your safety. Since that incident, if a petrol sniffer is to be transferred to a hospital the police are always asked to escort the patient.

41 – About to drive on visit to outstation when vehicle windscreen smashed with stick by a youth who had been sniffing petrol.

43 – Domestic violence and child physical abuse. Wife eventually – after many visits to our clinic and talking to me when "down the street" off duty – just bouncing ideas off everyone – left husband who attempted overdose. He survived, harassed wife and others, history of violence in ... (another country)... – until he left the country – we worried as psych profile of violent man, death threats to his family – police involved. We worried we were targeted as we helped his wife into safe house.

44 – I am not living in an Aboriginal community.

45 – My most personally threatening incidents have been with non Aboriginal education department employees who are suffering from stress and not coping with their work situations, putting pressure on their home life and ultimately

becoming violent to people and/or things – or inappropriate sexual behaviour – most incidents involving Aboriginal people are dealt with quietly and appropriately by the community council members. One other incident occurred where I was physically threatened by a AHW under pressure from her family to break a dept policy rule and placing me in a very difficult situation. She in fact was dissuaded from assaulting me by her family members and community members without me intervening at all. I actually have felt very supported and protected by the Aboriginal community and my safety seems paramount to them and most of the non Aboriginal population – but the community council will not intervene in non Aboriginal assaults and govt depts do not appear to want to take responsibility for their own staff when working in remote communities.

46 - A couple of weeks ago I was asked to attend to a client who was reported to be abusive and angry to other members of the community. This client was/is a known schizophrenic. When I approached him in what I believed to be a non threatening manner and asked about "how was he feeling etc" he swore and attempted to grab my hand to then take a "swipe" at me. Luckily I pulled my hands away and managed to run away, get in my car and drive off – by this time the man was shouting and starting to throw stones at the car. He then went for the AHW who managed to get out of his range of fire. (She was trying to pacify him and get me away.) Unfortunately there was no police to help (I thought we would've had to give him IV sedation) but luckily he was pacified by the police aid who persuaded him to take some medication – which was my initial goal! This man remained aggressive and verbally abusive in the clinic – mainly toward women (using extremely "unkind" terms for the female!) He was managed in the community by sending out people he accepted to give anti psychotic medication – he didn't go to ward I still feel uneasy when he is in the clinic especially on the w/end if I'm alone in the clinic. Another aspect of abuse which I find very difficult to cope with is "professional abuse" eg: being told you're a "rubbish nurse; or no good" or "you don't know what you're doing" – that sort of thing which has happened about 4 x in this last 12 months. Especially if the abuse is unfounded and unreasonable. I think probably because I work so bloody hard to help the community being put down professionally is worse than a slap-in-the-face. We get very little thanks for the work done on remote communities and having this sort of abuse I believe, adds to the "shelf life" of the job eg: 2yrs for a lot of nurses. I hope I have been of use to your research. Thanks.

47 – A male obviously intoxicated fell in the hotel bar and lacerated his forehead – 12 midnight I was called, he growled at me like a dog and weavily threw punches into the air at me. Not a pleasant time. I called the assistance of the publican's wife and under my instructions she cleansed the wound and applied steri strips – very effectively – and a bandage – which stayed in site for a short time. The steri strips were too hard for him to remove. He was put to bed at the hotel, stayed 10 minutes then tried to drive his car!! I rang a community member and they came and drove him home 0 The growling commenced when I offered to do so – rather scary. I worried that night he would drive his vehicle there. Next day patient acted as if nothing happened and I redressed his wounds with no mention of the previous sleeplessness and fright I experienced.

48 – Had minimal instances of incidents in local community. Any fights have usually been at the local hotel/or just outside hotel when young men have had too much to drink. Most of fights I attend are domestic – at people's houses – police usually also involved unless out of district.

49 – I was assaulted in the health clinic by an Aboriginal male, bashing me with a nulla nulla, and tipping a desk onto my back. His intent was to "kill a white woman", and he might have achieved it if not for my physical fitness. ...

51 – I was verbally and physically threatened by a grandmother of a patient seen: she came fully prepared with her husband, daughter and son in law plus a few spectators. She was completely irrational and threatened me when I went to call the police, subsequently I didn't call the police. She stated that the police aide was sufficient (the person in question's uncle!) who went on to reprimand me about the way I should talk to Aboriginal people. He was also present when the verbal and physical threats were being made and did not intervene. After the incident I called the police who went to see the person who said in front of the policeman OIC "I'll slap her for calling you to see me!" thus I spent the weekend in my flat recovering!

53 – I have not worked continuously in an A community in the past few years. I have returned to do relief on special project work with the community I originally worked in for 6 years. The incidents of verbal abuse were not unusual – but were confined ??? to being from 1 man and 4 women. They came about due to extreme frustration and anxiety the health worker suffered from this more than I did. We ??? together – went back to the person concerned and worked it out to understand the origins find with ??? and appropriate action – sometime however ??? day cooling off period was needed first. Sexual assault occurred once only. The person involved was not from the A community I worked in – but a visitor. I have never felt safe alone at night in a house since and even not very safe in a flat. The problem was that even though the health vehicle was immediately outside the door I could not get out (for 1 1/2 hours). Getting and keeping the men talking – working towards establishing each of us as fully human individuals seemed important and worked some of the time. After that the A community always looked "out" for me if I was alone in the house.

54 – Stalked by an Aboriginal man – drunk at my home. Not a permanent resident. Urinating on my verandah. I screamed turned lights on. Telephoned community elder – not at home. no other telephone. Did not want to venture outside. I live alone in isolated position near the clinic. Apparently he took off but too dark to see. Could not sleep that night. Told community members the next day. The man was given "belly down" and banished from community (he later returned a couple of months later). His defacto and child were most distressed at the time and considered me responsible for his leaving. This in turn influenced community feeling against me – isolating me even further. Payback can be an insidious feeling, so can being locked up at night with security lights and bolts, locks and keys.

55 – 1) Dealing with psychotic people as they withdraw from ETOH. When 1. The police refuse to assist to transport patient to safety of hospital. 2. Community elders are too scared to assist. 2) Attending to MVA at midnight while the drunken perpetrator threatens he beat you up. But! 3) Better than mad women attempting to strangle you!! –! wait for the full details in my forthcoming novel – "Life in Paradise!!"

56 – The area serviced by our ... centre is populated by anglo-saxon, northern european descent. There are no Koorie communities with which we have any contact. One Filipino lady resides here and one of Japanese origin. We so far have not encountered any sort of threatening incidents.

57 – Whilst sitting in local hotel, with my family and off-duty, I was approached by a local Aboriginal male to give him a lift some 40kms back to his community. When I refused he became verbally abusive and threatened me and my family with violence. He had to be restrained and removed by the local police officers after hotel staff contacted them.

58 – One of the 2 health workers on call was seeing a patient at home late at night when another patient presented with drunk parents demanding instant attention although the health worker was still busy with the first patient and the 2nd patient was non urgent. Next morning the health worker asked me to go and see the couple about their behaviour. I agreed and we went up to their house. To start off with I stayed back and didn't comment then the woman brought me into it saying we were lazy and why couldn't we help drunk people. I saw red as both the health workers and I had been very busy overnight and were tired and in fact we do deal with these drunk situations frequently and needless to say work hard. With my response I was then yelled at saying her husband was on the community council and would throw me off the community. The health worker and I left the scene to talk to a member of the health board. On the way we passed the police station where the health worker wanted to report the incident and see her husband. I burst into tears there. The health worker got angry with the treatment we had received went outside yelling about it attracting a crowd including supporting off duty healthworkers. The husband of the couple concerned was brought round and apologised and the women apologised to me at the clinic later that day.

59 – Threatened with physical violence by drug addict. Verbally abusive with raised fist would probably have gone further if other staff were not around at the time. Working in areas without adequate safeguards and when incidents occur no following counselling which result in a collection of experiences that remote and rural nurses carry around with them affecting both life and work performance.

60 – I was on call at night, busy dealing with a sick baby in one section of the clinic when a spade was thrown through a whole panel of louvres at the front of the clinic. The perpetrator apparently was angry because his wife had been sent into the regional hospital to await confinement and he was upset about it.

61 – At 3.30am one night, I was called to attend to someone who was at the local pub and had fallen over hitting their head, receiving a laceration which required suturing. It was also stated by one witness that the person involved looked as though they'd fittet. The person was "under the influence" and aggressive – not wanting to get into the hospital vehicle to be checked out and attended to. With the assistance of a friend of the 'victim', we finally (45 minutes later) persuaded the individual to go to the hospital in the friend's car. No verbal abuse was aimed at me directly, however fists were raised at one point. I kept my distance at such times, but I do remember thinking, should I be calling the police. As I didn't want to cause that sort of extra trouble, I didn't ring the police and thankfully I was finally able to examine the person at the hospital and was able to suture their wound.

63 – I am not aware that staff safety and/or security is a problem or has been a problem.

65 – An after hours call out, about 1am. Drunken male with laceration to forehead, after an incident in local pub. client using foul language to describe incident and feelings. Behaviour and language became unaggressive when

treatment explain and commenced. Also, companions soothed client's behaviour. No further problems.

69 – A client presented stating he had a lesion on his penis, and wanted me to examine it, he was very intoxicated, and was making lewd and suggestive comments to me and was laughing, I refused to see him, my male colleague took him into another room, spoke to him, examined him, then I went into the room and examined him – but avoided eye contact with him. I felt very uncomfortable in his presence and still do. I was involved in the resuscitation of a murder victim, recently, and this was a difficult situation, very stressful and many people involved – who were upset and drunk, I was concerned some of the people would become violent towards each other, but this was not so. We were concerned about the safety of others as the offender was not found for a while, but he did not harm anyone else.

70 – ... At work in the clinic, lady wished to use health phone to make a private call. I was obviously being tested as I was new to community – advised lady to use council office phone. Was verbally abused with foul language. you F— white c— etc. She walked up and down the clinic with a large stick – threatened to smash the clinic windows, me, phones, etc. I stood my ground patiently waiting for her to finish her speech. I didn't show I was frightened and told her she'd answer to the council if anything happened to the clinic and that I really didn't care I was only working there. This lady calmed down and left the clinic. I later found out ... he was badly beaten up by her She had spent time in jail ... Can describe many incidences over past 8–10yrs but only 2 in last 12 months.

71 – None.

72 – You have omitted a very important factor in this survey. That is the consention of alcohol by members of the community. A nurse came to work one morning and parked her car outside the health centre. Just as she was getting out of the car a very distressed young man shot the back window of her vehicle out with a shotgun at fairly close range. The nurse was uninjured but suffered critical incident stress and is still unable to work. The previous night the young man who was very dependent on his mother watched his mother die from myocardial infarction with his 5 other siblings. They were living off at an outstation with no communication facilities and no vehicle to bring his mother to the community. The young man was very distressed and so vented his despair on what he considered the lack of caring nurses.

73 – A sick 6yr old boy (viral illness) passed urine in a cupboard in the clinic, and I yelled at him to stop. His father grabbed me by the collar and hair and pulled me about yelling abuse, kicking and punching the walls.

75 – The vandalism of 2 cars belonging to 2 ... employees. The damage to one car was quite extensive. Apparently done by someone that was not from our community. The response by the community was one of apathy. There appears to be acceptance of property damage and no desire by the community to deal with the situation, this was not the case when, I first stated working in this community ... years ago.

76 – Drunk patient but friends of patient managed to keep him sufficiently controlled.

77 – We have to leave communities prior to sunset or else we can't take off – at least not from this one, which has no lights or flares. Otherwise can't do next day's clinics. Had to pack up and go in spite of waiting patients, one of whom became ????? and started throwing rocks at vehicle and us.

Man started throwing rocks at aircraft. Wanted to get one of our passengers.

Assaulted during descent by man who struck me repeatedly because I would not undo seat belt. At least I could get away from him – sort of.

Hit by walking stick when would not give patient "medicine". Eventually gave her antibiotics so she would stop yelling. They were an instant cure.

Incidents in aircraft are scariest because of inaccessibility of help and vulnerable situation. ie: enclosed space, danger of accident if patient does any real damage. Don't like to examine incidents too closely. They become too real again.

79 – I won't add any further the incident I described in 5(c) was the worst I saw. Since then, I have never felt safe as a RAN, especially after hours doing call. Every dog bark, or drunken fight in another language that catches my attention makes me anxious. It's like a reminder of that night. There IS nothing between you and death, rape or injury if you live and work in this situation – when you know the only protectors (the local police) are so badly injured you're battling to keep them alive and keep their morals up and there is NO-ONE else to help. It is the most dreadful feeling of ultimate ISOLATION, TERROR AND POWERLESSNESS. It also opens your eyes to the 'darker' side of human nature – death, murder, rape and mutilation do happen in these communities and as an outsider you are usually not aware of many of the agendas associated with them. Not understanding the cultural ???? causes an anxiety of uncertainty in your every assessment and communication the because your culture is in the minority and you don't know theirs well enough. I could go on.....! I went back and worked over 6 months after the incident to get it out of my system and I got to be 'more' comfortable as a RAN but not over that anxiety or fear especially during night call outs.

80 – A 16yr old man was brought in by his father and friends (6 adults), following "unusual" behaviour. A community policemen (sic) also accompanied him out left shortly after arriving at the hospital. The 16yr old appeared to be under the influence of drugs. All the other men were drunk and unhelpful. The 16 yr old was sexually explicit to me, tried to lock me in the room and jammed me up against the wall and grabbed me around the neck, saying he wanted to have sex. It was impossible to reason with him or to ascertain whether he was having a psychotic episode or just "acting out", At one point he pulled out his penis and started to masturbate. The state policeman was called, and the MO on call, both of whom only exacerbated the situation, eventually the man was given haloperidol IV and then diazepam, with 4 people holding him down. The female MO had also been jammed against the wall and was struck by the client. The policemen slept in the same room overnight with the client, as there was only 1 RN on duty and he felt unsafe.

81 – 18 months ago a group of 3 Aboriginal people initiated an assault on a group of white residents in the community on the occasion of a christmas tree for all local children. The people were assaulted with sticks, punched kicked etc while endeavouring to escape. During the course of the attack vehicles and property were damaged. Some of the Aboriginal assailants were driving around in a ute with rifles which were not in the end used. But these people were allegedly looking for the 'whites'. This incident lasted over a period of about 4 hours ... Police initially too afraid to take appropriate action. 3 police including ???? police are no longer in the force – out on stress leave. Nursing staff received counselling....

92 – One question not addressed in this questionnaire is those incidents where violence, although not condoned, is understandable!! Let me explain.

A ???? RN was appointed to the community. She had already been dismissed from another ... health service. She was abrupt and rude to the local Aboriginal people (even though she could never see this). This rudeness brought about bad feelings between her, a senior female HW and the Ab boss of the clinic. On one occasion she shamed in public and in a very severe manner, the boss (a male of much standing in the community) of the clinic – she abused him; called him a fool +++. He did nothing to her. After two days, she went to him to apologise – and although she was sincere in her apology, she still blamed him for the incident occurring. She finished her round and reported to the Administrator (of the regional AB controlled health services) that there had been a problem, but she talked to the person involved and he said "OK". The administrator reappointed her to the same community about a month later, with no consultation with the community or even the boss of the local clinic. She continued in her usual abrupt and rude fashion and the clinic was not a very happy place. The whole episode came to a head one day in the clinic when the RN was shouting at the boss and abusing him, and he put his hands around her throat and shook her. So the violence cannot be condoned, but it is totally understandable and the violence, although perpetrated by an Aboriginal male, I would be reluctant to lay the blame for it on his shoulder. The woman should never have been employed or re-employed; the community should have been consulted; her (RNs) understanding of her own skills and limitations was very wanting. Here, a point worth making in the whole debate about violence in the workplace, is that violence of one sort (verbal attitudinal, cultural) is often met with violence of another type (physical).

93 – 1) Called out at approx 0300 by people excited and agitated telling me of their concern regarding a young female who was stiff and unresponsive. The people conveying this information were exhibiting signs and behaviour of substance abuse. Together with the security man on call I responded, taking with me the people making the request for assistance. We arrived at the house approx 5–10mins later. People at the house were all (except one female) drinking cans of beer and showing signs of intoxication. I examined the young female lying on a mattress on the floor and she eventually responded from a stuporised state. her immediate reaction was – 'Get out of here you fucking white cunt, I don't need you, get out of this house!!' I left immediately.

2) Called to the canteen (pub) by phone approx 2100hrs, told a female had been stabbed in the heart. Arrived at the pub within 5 mins with security man. Client walked out to ambulance escorted by community police and male friend. She was very vocal saying "I've been stabbed in the heart". Transported back to the clinic client continued to verbalise and wouldn't sit down in the ambulance which was a problem – for the driver. Arrived at clinic and examined this very unco-operative female. The knife wound was superficial and the client was VERY verbal in her refusal to be sutured. (2 sutures would have sufficed) She insisted over and over and over again that her heart could be affected. I eventually steri-stripped the wound and repeatedly reassured the client. At 0330 I was called out by relations of this same client saying she couldn't breathe. With my security person I attended the clients' home. She was vocal and belligerent, attitude towards me was hostile – this hostility was also echoed by some of the people with her; signs of heavy alcohol consumption were visible. My security person and I did not attempt to enter the dwelling. I offered to take the client back to the clinic for re-assessment, she refused. My alternative offer was to go back to the clinic and return with appropriate

remove any person from area, though a flight could have flown police (if available) into area to stay the night. *Police still did not have personnel available to attend unless there was further incident (including threat to nurses) and then they would have to attend via road transport. *As there was no risk to the woman's health RFDS could not cover costs of a charter to hospital. *Hospital would have admitted wife if she had been able to get there. *Police were asked by the senior nurse to contact warden and project officer, inform them of events and ask them to return to area from hospital in order to support the few wardens remaining in area. *Director of community nursing centre gave us his home phone number in order that more senior police (regional) could be contacted after hours if further problems ensued. *Mr X Admin Assistance at hospital reminded us to evacuate area by road if required.

The clinic was not opened again that day. ... camp was visited and wife's safety ensured through family and women's supports. Wife injuries were reviewed. Health department vehicles x2 were secured in available garage space with third (oldest) vehicle beside nurses residence with gate locked. emergency care only was given to those requesting health services.

TUESDAY

0355hrs. Metallic banging sound were heard in the vicinity of one garage where a health vehicle was secured. Wardens attended as soon as notified by phone and had been, and continued to patrol throughout the night.

0800hrs. There was noted to be signs of damage to the padlock securing the garage – related to the 0355 hrs incident. Wardens were thanked for their support overnight: they (the wardens) could not understand why the police were taking so long in coming.

0910hrs. Husband came to clinic requesting "key..key..key". Police were contacted immediately of husband's agitated stance – police were about to leave in a chartered flight to attend to this matter. Warden struggle with husband outside the clinic and husband threw a rock which broke the front windscreen of a health vehicle. Warden rang police and the wardens continued to patrol the community until the police arrived at approximately 1030hrs.

THIS REPORT WAS SENT TO VARIOUS DEPTS INCLUDING HEALTH DEPARTMENT. IN THE FINAL STAGES IT WAS STATED THERE WAS AN EXPECTATION OF HEALTH SERVICE MANAGEMENT THAT THIS EVENT AND ITS CONSEQUENCES BE DISCUSSED WITH HIGHER AUTHORITIES WITHIN THE POLICE DEPT AND APPROPRIATE RESOURCING ADJUSTMENTS BE CONSIDERED A PRIORITY IN THE POLICE DEPTS PLANNING FOR THIS SHIRE.

PS: 4 WEEKS LATER THE POLICE INSPECTOR VISITED. LUNCH AND AN HOUR'S FORMAL BUSINESS ONLY REVEALED THE POLICE'S SHORTAGE OF RESOURCES.

97 – I have outlined the incident with the sexually offensive literature being left in my presence. It is anonymous and I have absolutely no idea who has left it. I am pretty certain that it is not a work colleague but a psycho in the community. I am ignoring it because there would be more attention brought to myself if I reported it that may encourage its continuance. It has occurred twice in 3/12. My biggest security is my dog. Although she is small she has a fierce bark and

is an extremely good watch dog. Being single and in a community where nurses have a reasonably high profile I feel very safe with my dog. There has been discussion by management for staff to have "duress" alarms that can bring help from the local police if an incident happens AT THE CLINIC. There is also discussion happening to provide us with satellite phones for call work that takes us out of the clinic. We are urged to contact police for accompanying us to emergency work at night outside of the clinic. I have used this once.

*Please note that all emphases made in upper case in Appendix 3 were those made by respondents and are not the emphases of the researchers.