



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Submission to the Examination of Children Affected by Family and Domestic Violence

June 2015

Introduction

The National Rural Health Alliance is the peak non-government organisation working in Australia for improved rural and remote health. It comprises 37 national organisations and is committed to better health and wellbeing for the more than 6.7 million people of rural and remote areas.

Members include consumer groups (such as the Country Women's Association of Australia and Health Consumers of Rural and Remote Australia), representation from the Aboriginal and Torres Strait Islander health sector (AIDA, NACCHO and IAHA), health professional organisations (representing doctors, nurses, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and the Council of Ambulance Authorities). The full list of Member Bodies is attached.

Each of the Member Bodies is represented on Council of the Alliance, which guides and informs policy development and submissions. With such a broad representative base, the Alliance is in a unique position to provide input on the broader issues relating to good health and wellbeing in rural and remote areas.

The Alliance welcomes this opportunity to provide input into the Australian Human Rights Commission's examination of children affected by domestic and family violence (D/FV).

The direct health impacts of domestic and family violence on children

D/FV can have a range of physical, emotional, psychological and behavioural impacts on children. These can include: depression; anxiety; trauma symptoms; increased aggression; antisocial behaviour; lower social competence; temperament problems; low self-esteem; the presence of pervasive fear; mood problems; loneliness; school difficulties; peer conflict; impaired cognitive functioning; and/or increased likelihood of substance abuse.

Eating disorders, teenage pregnancy, alcohol and drug abuse, mental health issues and suicide, delinquency and homelessness have also been associated with exposure to D/FV.¹

Exposure to D/FV as a child has also been associated with a higher likelihood of a range of problems occurring later in life, including: involvement in violent relationships with peers and conflict with adults and other forms of authority; increased risk of becoming perpetrators or victims themselves; and a detrimental impact on future parenting capacities.

Domestic and family violence data

In 2009, the National Council to Reduce Violence against Women and their Children (NCRVWC) released *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021*, which identified six key outcome areas. They are that:

- communities are safe and free from violence;
- relationships are respectful;

¹ Australian Government: Australian Institute of Criminology, Children's exposure to domestic violence in Australia (2011), http://aic.gov.au/media_library/publications/tandi_pdf/tandi419.pdf

- services meet the needs of women and their children;
- responses are just;
- perpetrators stop their violence; and
- systems work together effectively.

The strategies for each of these outcome areas include ‘build the evidence base’, noting that data relating to violence against women and their children in Australia is poor. Data on services sought by, and provided to, victims is not readily available, and the way in which information is recorded and reported is generally inconsistent.

For example, smaller emergency facilities are not required to report on the specifics of patient encounters. This means that information on D/FV-related encounters is not reported. This is in contrast to large emergency departments which are required to report more detailed information about patient encounters.

In addition to this, if the injury is serious enough, the victim is usually transferred to a large hospital, and counted in state-wide D/FV figures. If the injury is managed at the rural emergency facility, as would be likely for most contusions and wounds requiring suturing, such injury data is never collected or collated. This likely means that the scale of the problem in rural areas is under-represented in the data.

Because of this inconsistency, the prevalence and nature (i.e. the form of abuse) of D/FV in rural areas is not clear, with some research indicating higher rates than in urban areas while other research suggests the contrary. Research has instead focused predominantly on factors that make it more challenging for rural women to seek help and/or remove themselves from violent relationships. These include: financial insecurity; dependency; a perceived lack of confidentiality and anonymity; and stigma attached to the public disclosure of violence. Other research has focused on the connection between rural men's ideologies and masculinities and D/FV.²

The limited quantitative data that *are* available around the prevalence and nature of D/FV in rural areas are likely to under-represent the problem as people in these areas are less likely to report it for a variety of reasons outlined later in this submission.³

Without robust data around the prevalence and nature of D/FV, it will continue to be difficult to accurately identify those geographical locations and population groups where/among whom D/FV is most prevalent. As a consequence, it will be difficult for governments to implement effective prevention initiatives, program responses, support and legal services.

The prevalence of domestic and family violence in rural and remote Australia

In the Australian Bureau of Statistics' *Personal Safety Survey* (2005), 49 per cent of those who experienced violence by a current partner reported that they had children in their care at some time during the relationship, and of those, an estimated 27 per cent said that these children had witnessed the violence.⁴

² Australian Institute of Criminology, Emerging issues in domestic/family violence research (2010), http://www.aic.gov.au/documents/B/7/2/%7BB720C47B-56F2-4C4D-AA2C-57A2278FD87E%7Drip10_001.pdf

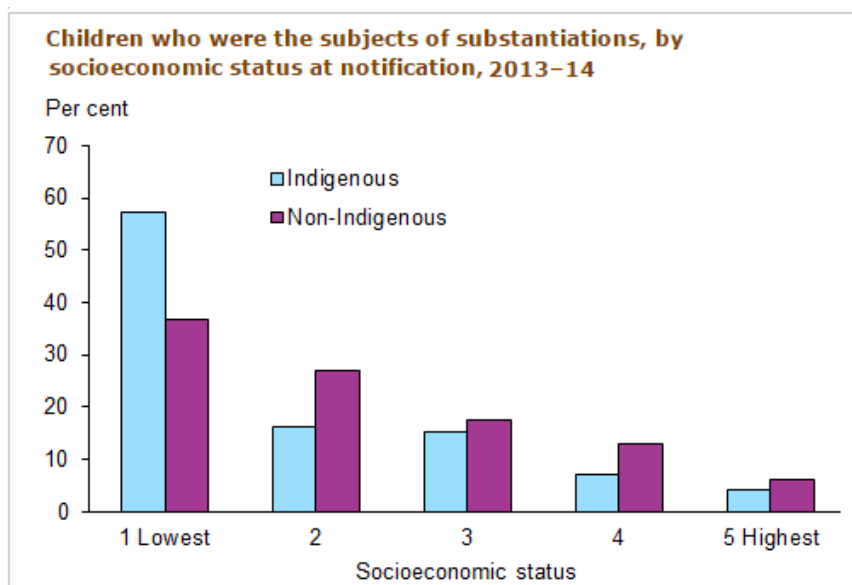
³ R Hogg and K Carrington, *Policing the rural crisis*, Federation Press, Annandale, 2006, pp. 149–159.

⁴ Australian Bureau of Statistics, *Personal Safety*, Australia, 2005 (Reissue) Cat No. 4906.0, [http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4906.0Main+Features12005%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4906.0Main+Features12005%20(Reissue)?OpenDocument)

There is a correlation between socioeconomic disadvantage and D/FV, and it is likely that this partly explains the higher prevalence of D/FV in rural areas.⁵ People in rural areas tend to be of poorer health, reside in poorer housing, have lower incomes, fewer employment prospects and lower educational attainment.⁶

The correlation between socioeconomic disadvantage and D/FV is particularly marked among Australia's Indigenous population (35 per cent of Indigenous Australians live in major cities, with 65 per cent living in rural areas).⁷

The Australian Institute of Health and Welfare (AIHW) recently reported on the interrelationship between remoteness, indigeneity, socioeconomic disadvantage and child abuse/neglect/harm. In its report, *Child Protection 2013-14*, the AIHW found that in 2013–14, Indigenous children were 7 times as likely as non-Indigenous children to be receiving child protection services (136.6 per 1,000 children compared with 19.0 for non-Indigenous children).⁸ It also found that, across jurisdictions with available data, around 42 per cent of the children who were the subjects of substantiated notifications⁹ were from the areas of the lowest socioeconomic status (SES) (see chart to follow). Indigenous children in this cohort were far more likely to be from areas of the lowest SES: 57 per cent compared to 37 per cent for non-Indigenous children.¹⁰



Source: Australian Institute of Health and Welfare, *Child protection Australia 2013-14*

In the absence of collated nation-wide data, research from South Australia also suggests that the prevalence of D/FV increases with remoteness. This research found that rates of substantiations

⁵ ABS, *Defining the Data Challenge for Family, Domestic and Sexual Violence*, 2013, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4529.0main+features100012013>

⁶ ABS, *Measures of Australia's Progress*, 2004, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/bb8db737e2af84b8ca2571780015701e/2b2d7742b4059b04ca256e7d00002658!OpenDocument>

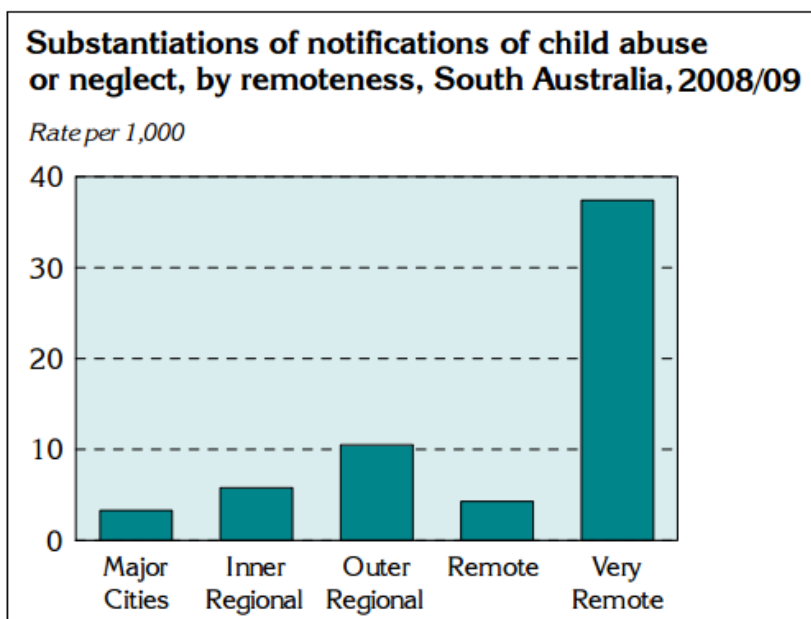
⁷ ABS, *Estimates of Aboriginal and Torres Strait Islander Australians*, June 2011 <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.0.55.001June%202011?OpenDocument>

⁸ AIHW, *Child Protection Australia 2013-14*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550859>

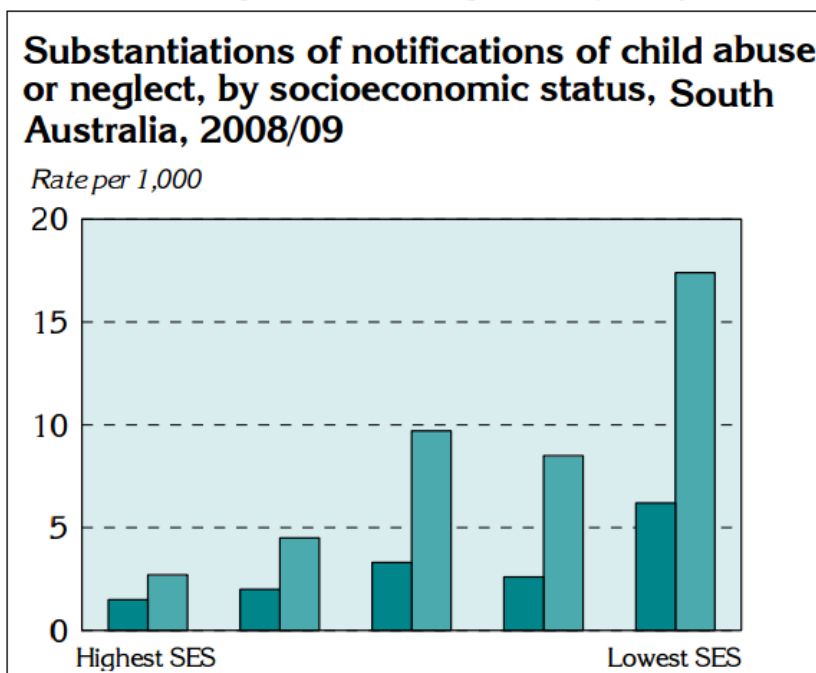
⁹ 'Substantiations of notifications' refer to child protection notifications made to relevant authorities which were investigated and where it was concluded that there was reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed.

¹⁰ AIHW, *Child protection Australia 2013-14*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550859>

of notifications of child abuse are highest in the most remote areas of the state, and in the most disadvantaged areas (see charts to follow).¹¹



Source: [Public Health Information Development Unit](#), University of Adelaide



Source: [Public Health Information Development Unit](#), University of Adelaide

Data from a study of domestic assaults reported to the police in NSW from 2001 to 2010 presents a similar case. Nineteen of the top 20 NSW Local Government Areas (LGAs) for domestic assault were rural or regional. The top five LGAs were all remote— Bourke, Walgett, Moree Plains, Coonamble and Wentworth.¹² It should be noted, however, that four of these five LGAs have large Aboriginal and Torres Strait Islander populations (20 to 30 per cent, with the

¹¹ Glover, J. et al, Understanding Educational Opportunities and Outcomes (2010), https://www.adelaide.edu.au/phidu/publications/pdf/2010-2014/sa-education-2010/education_sa_full.pdf

¹² NSW Bureau of Crime Statistics and Research, Trends and patterns in domestic violence assaults: 2001 to 2010, <http://www.bocsar.nsw.gov.au/Documents/bb61.pdf>

fifth at around ten per cent). As previously discussed, Indigenous Australians are much more likely to experience violence.¹³

Factors influencing offending and help-seeking behaviours in rural and remote areas

Research has identified a number of barriers to women seeking help, including: lack of available services; lack of knowledge of the support services that are available; concerns over a lack of confidentiality, coupled with perceptions of stigma; fear of reprisal from partners; a lack of confidence in enforcement of legislation by police (particularly among Aboriginal people); failure of individuals to recognise D/FV as a problem; concern that their children will be taken away; and the inability to support themselves and their children if they were to leave.^{14,15} Poor connectivity also compounds their isolation and inhibits access to support.¹⁶

Many small rural communities do not have specialist D/FV services, such as safe houses and shelters.¹⁷ In communities where these services *are* available, public transport is sometimes limited or non-existent, which means that the services may be inaccessible for some people. Similarly, many women in rural areas have limited or no options regarding legal representation.¹⁸

Victims' financial dependence (often stemming from the lack of employment opportunities) on the offender can also increase their vulnerability. In the absence of support services they may be forced to choose between remaining in the violent situation or potential homelessness and impoverishment.¹⁹ Victims are also often isolated from family members and friends who could offer support and temporary accommodation.

Under-resourcing of local police is also a problem for people in rural areas. In many rural areas, when a callout is made to a property, the sole police officer must first await backup from a neighbouring town, incurring long delays before travelling out to the farm or station. The situation is exacerbated in communities where there is only a part-time police officer stationed,

¹³ ABS, 2011 Census,

<http://www.abs.gov.au/websitedbs/censushome.nsf/home/quickstats?opendocument&navpos=220>

¹⁴ NHMRC, Report on a review of literature on the epidemiology of violence in rural and remote Australia and resources to the management of violence (2002)

https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/hp16lit.pdf

¹⁵ Australian Human Rights Commission, Rural responses to rural challenges: The need for a contextualised response to family and domestic violence (2013)

<https://www.humanrights.gov.au/news/speeches/rural-responses-rural-challenges-need-contextualised-response-family-and-domestic>

¹⁶ A Morgan and H Chadwick, 'Key issues in domestic violence', Research in Practice, 7 (2009)

<http://www.aic.gov.au/publications/current%20series/rip/1-10/07.html>

¹⁷ Australian Institute of Criminology, Key Issues in Domestic Violence (2009),

<http://www.aic.gov.au/publications/current%20series/rip/1-10/07.html>

¹⁸ Domestic Violence in Regional Australia - A Literature Review (2000), Partnerships Against Domestic Violence and Commonwealth Department of Transport and Regional Services, <http://wesnet.org.au/wp-content/uploads/2012/04/WESNET-Domestic-Violence-in-Regional-Australia-A-Literature-Review.pdf>

¹⁹ Australian Human Rights Commission, Rural responses to rural challenges: The need for a contextualised response to family and domestic violence (2013)

<https://www.humanrights.gov.au/news/speeches/rural-responses-rural-challenges-need-contextualised-response-family-and-domestic>

or there is no police presence at all.²⁰ Many Aboriginal people also carry a deep distrust of police and the legal system, which is a key barrier to reporting D/FV.^{21,22}

Excessive alcohol consumption is associated with all the major forms of child abuse and neglect: physical abuse; emotional maltreatment; neglect; sexual abuse; and the witnessing of D/FV.²³ In rural areas, alcohol consumption and its associated harms are consistently higher than in urban areas. The 2013 National Drug Strategy Household Survey shows that alcohol consumption was consistently higher in Remote and very remote areas and the proportion of those drinking at risky levels increased with increasing remoteness. Results showed 16.7 per cent, 19.1 per cent, 23 per cent and 35 per cent of people consumed alcohol at risky levels for lifetime risk, and 25 per cent, 27 per cent, 32 per cent and 42 per cent at risky levels for single occasion risk in, respectively, Major cities, Inner regional, Outer regional and Remote and very remote areas.²⁴

A number of studies have also identified a relationship between illicit drug use and child abuse.²⁵ While proportions of those who recently used illicit drugs showed only slight variation across regions – Major cities (15 per cent), Inner regional (14 per cent), Outer regional (15 per cent) and Remote/Very remote areas (17 per cent) – people in rural areas often face difficulties accessing drug treatment services. Services that are particularly limited in rural areas include, for example, methadone programs, withdrawal and detoxification services, as well as needle and syringe programs.²⁶ This may mean children whose parents are unable to access treatment services are more vulnerable.

Women experiencing domestic violence residing on stations or farms are also more vulnerable due to higher prevalence of firearms.²⁷

Programs and support services for those experiencing domestic violence and child abuse in rural and remote Australia

There are a number of programs and initiatives that have been established to address D/FV in rural Australia. Some examples are detailed to follow.

The Department of Prime Minister and Cabinet provides funding to the Centre for Remote Health to deliver accredited training to health professionals and community service workers working in remote areas of the Northern Territory.²⁸ The training covers:

²⁰ Domestic Violence in Regional Australia - A Literature Review (2000), Partnerships Against Domestic Violence and Commonwealth Department of Transport and Regional Services, <http://wesnet.org.au/wp-content/uploads/2012/04/WESNET-Domestic-Violence-in-Regional-Australia-A-Literature-Review.pdf>

²¹ <https://www.humanrights.gov.au/publications/social-justice-report-2003-chapter-5-addressing-family-violence-indigenous-communities>

²² Domestic Violence in Regional Australia - A Literature Review (2000), Partnerships Against Domestic Violence and Commonwealth Department of Transport and Regional Services, <http://wesnet.org.au/wp-content/uploads/2012/04/WESNET-Domestic-Violence-in-Regional-Australia-A-Literature-Review.pdf>

²³ Australian Institute of Family Studies, An overview of alcohol misuse and parenting, <https://www3.aifs.gov.au/cfca/publications/overview-alcohol-misuse-and-parenting>

²⁴ AIHW, National Drug Strategy Household Survey 2013, <http://www.aihw.gov.au/publication-detail/?id=60129549469&tab=3>

²⁵ Australian Institute of Family Studies, Child maltreatment and substance abuse (Website), <https://aifs.gov.au/cfca/publications/child-maltreatment-and-substance-abuse>

²⁶ NRHA, Illicit Drug Use in Rural Areas (2012), <http://ruralhealth.org.au/sites/default/files/publications/fact-sheet-33-illicit-drug-use-rural-australia.pdf>

²⁷ Domestic Violence in Regional Australia - A Literature Review (2000), Partnerships Against Domestic Violence and Commonwealth Department of Transport and Regional Services, <http://wesnet.org.au/wp-content/uploads/2012/04/WESNET-Domestic-Violence-in-Regional-Australia-A-Literature-Review.pdf>

- child sexual abuse, child neglect, emotional and physical abuse of children, and domestic violence;
- mandatory reporting and barriers and enablers to reporting;
- information required to make a child abuse report;
- child abuse prevention considerations and activities; and
- self care for primary health care practitioners.

Training in D/FV for health and allied health workers is also delivered through the national [DVAlert](#) program. In addition to online courses, priority is given to holding courses in rural and regional locations. Work is underway to enhance the training available to Aboriginal Health Workers. Financial assistance with travel costs is also available for workers from rural locations.²⁹

Some Aboriginal communities have set up safe houses offering short-term accommodation to women and children who have experienced family violence or are escaping the threat of violence from husbands or partners. The safe house at Yuendumu in the Northern Territory, for example, has a 3-metre fence and locked gate with intercom. Women can gain access anytime by talking to known community members who have keys. Rules and rights govern the women's stay. Alcohol is prohibited, and women are free to decide if they want to report incidents of domestic violence.^{30,31}

The 24 hour national telephone and online counselling service for victims of D/FV and sexual assault, *1800 RESPECT*, provides access to professional counselling. Assistance is also available to family and friends and people working in services who are working with victims of domestic violence and sexual assault.³² *Mensline* (1300 789 978) is a 24 hour service for men who want to better manage primary relationship difficulties and this can include male victims of domestic violence. LawAccess (NSW) is a government telephone service which provides legal information, advice and referral for people who have a legal problem involving domestic violence. All of these services are available to rural people, if they have access to a telephone.

While there are some programs, services and educational materials available to rural people, there has been little research into their effectiveness in addressing the issue of D/FV.

Recommendations

The NRHA recommendations that:

1. Governments fund public awareness and education campaigns around D/FV that are specifically targeted at rural communities. Such campaigns should include:

²⁸Rural and Regional Health Australia (Website):

http://ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/NT_Remote_Health_Workforce_Child_Abuse_Training_and_Development

²⁹ DVAlert (Website), <http://www.dvalert.org.au>

³⁰ 'Communities confronting family violence', Aboriginal and Torres Strait Islander Social Justice Commissioner, Social Justice Report Community Guide 2007', cited in Creative Spirits, Domestic and family violence, <http://www.creativespirits.info/aboriginalculture/people/domestic-and-family-violence#axzz3aSv23gvn>

³¹ NHMRC, Report on a review of literature on the epidemiology of violence in rural and remote Australia and resources to the management of violence (2002)

https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/hp16lit.pdf

³² 1800Respect (Website), <https://www.1800respect.org.au/>

- hosting a series of public forums on family violence in its various forms including emotional, psychological and financial violence and its potential harms to women and children;
- coordinating a suite of preventative campaigns in conjunction with local government, regional police and other key stakeholders about D/FV developed and delivered to men and organisations where men gather in regional, rural and remote areas;
- promoting awareness of the support programs and services available to people in rural and remote areas (this might include the development of an online 'find a service near you' referral tool);
- encouraging victims and those who have witnessed D/FV to report it (and providing information on how to do so anonymously); and,
- working with the Department of Education and Training to develop school-based education programs around gender, relationships, family and 'safe spaces' to discuss D/FV.

2. Governments establish a nationally consistent system for monitoring the prevalence of D/FV. Prevalence should be examined and reported by geographical location and population group to allow for more accurate targeting of programs and services.

3. Commonwealth and State governments allocate funds to D/FV support services in D/FV 'hot spots'. This should include a heightened police and social worker presence, culturally appropriate crisis accommodation, and short- and long-term social housing options.

4. Governments fund training for the health workforce (including Aboriginal Health Workers), school teachers, sports coaches and others who have regular face-to-face contact with children in rural areas. Training programs should focus on helping health workers to:

- better identify possible presentations, signs and symptoms of family violence;
- better understand the challenges survivors of family violence face;
- respond appropriately to suspected cases and disclosure of family violence;
- provide referral to support services;
- document abuse; and,
- address the safety of victims.

5. The Human Rights Commission in its examination of D/FV undertakes robust consultation with rural communities and specialist service providers (such as women's refuges). These communities and providers face a range of unique challenges (just some of which have been outlined above) which warrant a heightened research and policy focus.

ATTACHMENT

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANaplus	CRANaplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group)
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)