



RACGP

Royal Australian College of General Practitioners

General practice – A safe place

A guide for the prevention and management of patient-initiated violence



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A guide for the prevention and management of patient-initiated violence

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We recognise the traditional custodians of the land and sea on which we work and live.

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This guide is, in part, a collection and adaptation of the work by prominent people in the field of general practice and occupational violence.

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Foreword

General practice teams need to work together to ensure that all individuals (patients, carers, staff and others) remain safe while within Australian general practices. *General practice – A safe place* is intended to help GPs and their practice teams proactively prevent and manage the risk and incidence of patient-initiated violence.

Studies indicate that more than 60% of Australian GPs and their practice teams experience some form of patient-initiated violence each year. The most prevalent forms of patient-initiated violence are verbal/written aggression, followed by property damage and theft, then physical assault, sexual harassment and stalking.

The psychological and physical impact on the recipient and broader practice team can be significant, negatively impacting their personal wellbeing, professional performance and social participation. The symptoms often manifest as anxiety, depression, stress-related illness, difficulty listening to patients, avoiding certain patients, diminished productivity, absenteeism and high staff turnover.

To date, patient-initiated violence has largely been addressed on an ad hoc basis. However, there is a range of human and contextual factors that can be proactively managed to reduce the risk, incidence and impact of patient-initiated violence.

As employers, GPs also have responsibilities under occupational health and safety (OHS) legislation to protect colleagues and staff by identifying and controlling risks associated with all forms of occupational violence.

Patient-initiated violence is also increasingly being recognised as an adverse event – hence being addressed by clinical risk management systems in mental health clinics, drug and alcohol services, locum agencies, hospitals and elsewhere.

In developing this guide, the authors have consulted with many experts in the field, and with practice teams working at the 'coalface'. In summation, it outlines a range of strategies that can be used as part of a practice-wide/systems approach to patient-initiated violence in Australian general practice.

Readers are invited to explore a range of common strategies used to:

- manage aggressive/violent patient encounters (section 2)
- prepare and support practice teams before, during and after an incident (section 3)
- create a safe work environment (section 4).

Importantly, this guide can also be used as an educational module attracting Quality Improvement and Continuing Professional Development (QI&CPD) points. Further information about how to use the reading material, case studies and questions for educational purposes can be found in the Introduction.

We recognise the issue is complex and requires different approaches in different situations. We hope that this guide will encourage discussion within general practice teams and help them determine the most appropriate strategy to meet their unique practice needs.

Before implementing any of the strategies described here, ensure that you and your practice team understand the associated legalities detailed in section 5. Where in doubt about your medico-legal standing in relation to any scenario, always contact your medical indemnity insurer.

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Introduction

Occupational violence is symptomatic of the overall prevalence of major violence in Australia.¹ Although it occurs in a broad range of occupational settings, healthcare workers are at relatively high risk of exposure.²

During the last decade, efforts to improve the occupational health and safety of health professionals have been substantial, particularly within mental health services, drug and alcohol services, locum agencies and hospitals. However, evidence suggests that there is a need to improve health workers' understanding of the systems and processes that are being introduced and embed this within organisational cultures.³

A widely accepted classification of occupational violence, developed by the Californian Occupational Safety and Health Administration, divides it into three broad categories:

- external violence – such as an armed hold-up perpetrated by an external aggressor
- internal violence – such as bullying perpetrated by an employee/manager
- patient-initiated violence – such as verbal abuse perpetrated by a patient.^{4,5,6}

This guide only considers the third category – patient-initiated violence.

Patient-initiated violence is not an isolated incident with a simple solution. It is a dynamic and multidimensional event that requires a multifaceted response.⁶ Past initiatives to address patient-initiated violence in general practice have tended to be ad hoc. They have seldom been carefully considered and coordinated strategies.^{7,8}

This guide proposes a practice-wide/systems approach to patient-initiated violence encompassing the:

- doctor–patient encounter
- general practice team
- general practice environment.

The tips and tools included throughout the guide are for use in response to imminent or actual threats to personal safety. They are not intended to assist with the day-to-day management of 'difficult' patient encounters, nor for conflict resolution.

Aim

This resource is intended to help general practice teams manage risks and instances of patient-initiated violence by developing:

- knowledge of:
 - factors that increase the risk of patient-initiated violence occurring
 - early warning signs and the cycle of aggression
 - strategies to manage risks and incidents
 - medico-legal issues associated with use of each strategy
- skills to:
 - prevent patient-initiated violence
 - manage aggressive patients during the patient encounter
 - initiate post-incident response in accordance with the relevant regulatory frameworks
 - discontinue patient care where safety concerns exist
 - prepare and support the practice team prior to, during and after an incident
 - create a safer practice environment by incorporating principles of 'crime prevention through environmental design'.

RACGP curriculum

Patient-initiated violence of any type is considered an adverse event that needs to be understood and managed like any other clinical risk or incident. The content of this guide is therefore aligned with *The RACGP curriculum statement for Australian general practice 2011: Quality and safety*.

Quality in healthcare is a measure of the extent to which the best possible health outcomes are achieved given available resources and other constraints. Safety in healthcare is reducing the risk of unnecessary harm to an acceptable minimum level.

A combination of human, task-related and contextual factors influence quality and safety of patient care. Even patients can play an active role in maintaining the quality and safety of their own care, or compromising it – as is the case with patient-initiated violence.

Hence, risk and incident management strategies need to engage the patient, the treating healthcare team, and shape the surrounding clinical setting. A holistic systems approach to patient-initiated violence identifies all the contributing factors in a practice environment, and builds practice-wide safeguards against potential threats.

While the overall approach taken by each practice may vary, most approaches include use of common techniques and tools for risk monitoring and reporting, incident logging, flagging patient records, issuing formal warnings, using acceptable behaviour agreements, making alternate treatment arrangements, and safely discontinuing care.

Preparing and supporting the entire practice team prior to, during and after an incident should also become swift standard practice, supported by a practice-wide safety culture, leadership and environmental design that recognises the inevitability of risks, acts on opportunities to mitigate them, and inspires all practice staff to collaboratively contribute to safety enhancements.

A practice-wide/systems approach will help address the needs of patients, the practice team and the wider community in a balanced, responsive and cost-effective way.

For more information about this topic, see the RACGP curriculum statements on quality, safety and practice management available at <http://curriculum.racgp.org.au>.

Domains of general practice

The content is intended to help achieve learning outcomes across the five domains of general practice (*Table i.1*).

Table i.1. Domains of general practice	
Domain 1	Communication skills and the patient–doctor relationship (eg patient centredness, health promotion, whole-person care)
Domain 2	Applied professional knowledge and skills (eg physical examination and procedural skills, medical conditions, decision making)
Domain 3	Population health and the context of general practice (eg epidemiology, public health, prevention, family influence on health, resources)
Domain 4	Professional and ethical role (eg duty of care, standards, self-appraisal, teacher role, research, self-care, networks)
Domain 5	Organisational and legal dimensions (eg information technology, records, reporting, confidentiality, practice management)

Learning outcomes

Possible learning outcomes include:

- QAST1.1 Use effective communication, active listening skills, self-awareness and self-reflection to assess external and internal influences to help reduce hazards to safety.
- QAST2.2 Understand that changes in the person (eg change in cognitive state), the patient healthcare context (eg the emergence of new diseases) and in the nature of clinical care (eg advances in technology) all create changes that may increase the likelihood of harm to patients and practice staff.
- QAST2.3 Apply knowledge of the impact of human factors, such as the role of cognitive overload and resilience, in order to maximise the safety of patients.
- QAST2.7 Apply knowledge and skills in the identification of the causes of near misses and adverse events to reduce risk of harm in Australian general practice settings.
- QAST3.2 Know the epidemiology of harm, including the common causes of harm, and how this can focus attention on the most effective interventions for reducing risk of harm to patients.
- QAST4.6 Undertake quality assurance and improvement activities that reduce the likelihood of harm to patients.
- QAST5.1 Understand that systems-based approaches to health that focus on quality and safety are likely to produce a safer healthcare environment, thus complementing the person-based approach.
- QAST5.6 Understand that the development of an open, transparent, supportive and just culture within the general practice setting is regarded as the foundation of safety for patients and members of the healthcare team.
- QAST5.8 Report on incidents including lapses in safety, slips, errors, mistakes, near misses and adverse events within the practice.
- QAST5.9 Assist in the cultivation of meaningful and timely ways of reporting and acting on incident reports.
- QAST5.11 Understand general practice legal obligations (including those relating to medical indemnity insurers), especially in the context of the discussion of adverse events.

See the RACGP statement on quality and safety (<http://curriculum.racgp.org.au/statements/quality-and-safety>) for an expanded list of possible quality and safety learning outcomes across each domain of general practice.

Target audience

This resource is intended for use by the entire general practice team. This includes experienced GPs, registrars, medical students, allied health professionals, practice nurses, practice managers and administrative staff.

How to use this resource

This resource can be used as a stand-alone guide on clinical risk management in general practice, or to assist with the completion of an RACGP QI&CPD activity such as:

- an individual (self-directed) active learning module (ALM)
- an online *gplearning* ALM
- a small-group learning (SGL) activity.

When used as part of an educational activity, learners have the opportunity to gain additional:

- quality improvement recognition
- QI&CPD points through completion of individual or group plan, do, study, act (PDSA) cycles.

This guide contains practical advice in sections 1–5, followed by five case studies, related questions and further reading.

ALMs

ALMs are structured educational activities intended to improve GPs' clinical practice by enhancing their clinical knowledge, skills, attitudes and behaviours in a demonstrable way.

All the ALM components can be completed in a minimum of six hours – excluding the predisposing and reinforcing activities (Table i.2).

Table i.2. ALM components by section

Section	ALM component	Time allocation	Pages
i.	Predisposing activity	30 minutes	6–7
6.	Case studies and questions	180 minutes	55–63
7.	Practice-based activity	90 minutes	64
7.	Community-based activity	90 minutes	64–65
8.	Reinforcing activity	30 minutes	66–68

Individual (self-directed) ALM

To be eligible for 40 Category 1 QI&CPD points, individual learners must:

- identify three to five measurable learning outcomes that can be mapped to the RACGP curriculum and domains of general practice
- ensure that at least one learning outcome addresses a systems approach to patient safety
- complete a minimum of six hours of structured educational content (excluding predisposing and reinforcing activities)
- ensure that more than two-thirds of this time is interactive or experiential. This can involve:
 - answering the included questions
 - discussing the included management strategies, case studies, questions, and/or further reading
 - role playing.

glearning ALM

The activities in this resource can also be completed online as a *glearning* activity that has been pre-approved as part of the RACGP QI&CPD Program for 40 Category 1 points. More information about this option can be accessed by logging into the *glearning* portal via the RACGP website (www.racgp.org.au).

SGL

To be eligible for 40 Category 1 QI&CPD points as participants in an SGL activity, learners must:

- have a minimum of two GP participants and a maximum of 12 participants
- convene a documented planning meeting
- determine three to five measurable learning outcomes that can be mapped to the RACGP curriculum and domains of general practice
- ensure that at least one learning outcome addresses a systems approach to patient safety
- plan a series of sessions to achieve the agreed goals
- ensure individual sessions are at least one hour in duration
- complete a minimum of six hours of educational content
- convene a documented review meeting upon completion of the SGL activity.

PDSA cycles

These are optional extra activities, worth an additional 40 Category 1 QI&CPD points. A PDSA cycle refers to a ‘trial-based’ learning approach in which a quality improvement initiative is tested on a small scale before any changes are made to the wider system.

This is a cyclic process because a desired improvement might not be achieved in one cycle, hence the need to refine the original plan and repeat the process until the desired result is achieved.

Individual PDSA cycles

For individual learners to be eligible for an additional 40 Category 1 QI&CPD points, they must complete a minimum of two rapid PDSA cycles within a three-month period. This is in addition to meeting all the requirements for each individual (self-directed) ALM listed above.

Group PDSA cycles

For small-group learners to be eligible for an additional 40 Category 1 QI&CPD points, they must complete a minimum of two rapid PDSA cycles within a three-month period. This process must be led by an appointed facilitator. This is in addition to meeting all the requirements for the SGL activity listed above.

More information can be found in the RACGP *QI&CPD Program: 2014–16 triennium handbook*, available at www.racgp.org.au/download/Documents/QICPD/QICPD-Handbook.pdf

Documented evidence

Evidence of successful completion must be recorded and submitted to your state faculty QI&CPD unit in the prescribed application forms for approval of:

- individual (self-directed) learning activities
- SGL activities
- PDSA activities.

The online application forms can be accessed by logging into your account via the GP dashboard located within the RACGP website at www.racgp.org.au. For further information, please contact your state faculty QI&CPD team.

Reading and references

Recommended reading is included within each section. All recommended reading material is available from the RACGP John Murtagh Library or can be downloaded free of charge to members via the RACGP website. A full list of references is provided at the end of the guide.

Predisposing activity

Instructions

This is intended for use as part of an ALM. To be eligible for the maximum number of QI&CPD Category 1 points, this activity must be completed before you work through the remainder of the guide.

This predisposing activity should take approximately 30 minutes to complete. Feedback is not provided for your answers. Many of the same questions will be asked in the reinforcing activity and you will receive feedback at that stage.

The aim of this predisposing activity is to explore your current understanding of patient-initiated violence. There is no need to consult external references to answer questions. Your results are not graded, so please simply record your immediate, personal response to questions.

If you are not in clinical practice when completing this activity, answer the questions by recalling your actions and thoughts when you were last practising or stating what you believe they would currently be.

Please write answers to the following questions.

1. How would you define patient-initiated violence?

2. Do you consider the risk of patient-initiated violence to be 'part of the job'?

3. What would you do if a patient became aggressive during a consultation?

4. How would you manage the situation of a patient requesting benzodiazepines or other drugs of addiction?

5. Under what circumstances would you undertake a home visit for a new patient, or a patient requesting specific analgesia, or a patient previously known to behave aggressively?

6. Would you refuse to treat a patient who became aggressive?

7. If so, how would you go about terminating the therapeutic relationship?

8. What features of consulting room and practice design may improve the physical safety of staff?

9. What medico-legal considerations are associated with different types of intervention?

10. Please reflect on the learning outcomes described in the introduction and set your own.

You have finished the patient-initiated violence predisposing activity.

1. Understanding patient-initiated violence

1.1 Definition of patient-initiated violence

For the purposes of this guide, patient-initiated violence includes incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, wellbeing or health.⁵

There are varying types and degrees of patient-initiated violence. Violent behaviour is not purely restricted to the domain of verbal or physical aggression. What one person perceives as threatening may be perceived quite differently by another person.

Patient-initiated violence covers a wide spectrum of behaviours and actions, including:

- verbal aggression (including rudeness, yelling, swearing)
- intimidation and threats
- abusive letters/phone calls/emails
- threatening or inappropriate body language
- assault/armed assault
- forcible confinement/false imprisonment
- acts of indecency
- sexual assault
- destruction of property/possessions
- stalking, loitering
- a hostage situation.^{7,9-11}

In essence, patient-initiated violence includes anything that makes a person feel threatened or causes psychological or physical harm. While many patients express anger, it usually resolves with respectful communication; very few patients react violently. What is most important is that people always acknowledge and act on their 'gut' feeling when they feel threatened.

1.1.1 Assault

Most people equate assault with physical violence. Yet physical violence is only one type of assault. Due to this misunderstanding, it is important to explain what assault is.

Assault has a different statutory definition in each Australian state and territory.¹² However, common law assault is generally understood as *the intentional use of intimidation or force by one person against another, without the other person's consent or other lawful reason, which causes that other person to fear an immediate threat of physical violence or harm.*¹³ Such actions may result in either criminal or civil liability.¹⁴

It is important to note that conduct that is threatening and intimidating, but which falls short of an act of aggression involving physical touching, may constitute assault.¹⁵ For example, if a patient threatens another person by waving a weapon, such as a dirty syringe, in front of that person's face, this would constitute assault if it is done intentionally, and the act evokes fear in the person threatened.

1.1.2 Battery

In recent years the definition of assault has been extended to include acts that technically constitute battery. Battery is intentional physical contact with a person, without his or her consent, that results in bodily harm, or is offensive to a reasonable sense of dignity.

Battery includes actions such as:

- pushing
- shoving
- smacking
- holding
- touching a person's body or clothes so as to cause them discomfort.¹⁶

1.2 Prevalence

More than 60% of Australian GPs experience at least one episode of patient-initiated violence each year.^{7,17-19}

The most prevalent form of violence experienced is verbal and written aggression, followed by property damage, sexual harassment/assault, physical assault, then stalking.^{11,17,20,21}

This pattern persists over the course of GPs' careers²³ and is similar to the pattern of patient-initiated violence experienced by other clinical and non-clinical practice staff, as shown in Table 1.1.²²⁻²⁴

Table 1.1. Lifetime prevalence of patient-initiated violence in general practice

Type of aggression	GPs/general practice registrars	Other practice staff
Verbal or written aggression from patients	50%	33%
Property damage and theft	37%	20%
Sexual harassment	19%	14%
Physical assault	16%	11%
Stalking	11%	6%

1.3 Risk factors

Research suggests that the risk of patient-initiated violence occurring increases under certain conditions, depending on the characteristics of the patient, the practice team and the practice environment.

For example:

- younger, less experienced GPs are at higher risk of patient-initiated violence than older, more experienced GPs¹⁰
- female GPs are at higher risk of sexual harassment and assault (10%) compared to males (3%)¹⁰
- international medical graduates (IMGs) are more vulnerable to patient-initiated violence – with some studies suggesting that cultural and communication issues may serve as triggers^{21,25}
- certain times of the day pose a higher risk of patient-initiated violence – working outside normal business hours and at practice 'closing time' are perceived as particularly risky^{10,26}

- geographical location – GPs in urban areas are on average at higher risk compared to GPs in rural areas, with further variation existing within sub-regions⁷
- patient demographics/socio-economic status – mental illness, drug and alcohol use, poverty, unemployment and social dislocation heighten patient frustration, resentment and nihilism⁷
- practice size/staffing arrangements – larger practices, with more GPs and practice staff, have a greater number of patients attending, which increases the number of patient interactions and opportunity for patient-initiated violence.²²

1.4 Impacts

Patient-initiated violence can have a serious and widespread impact on the staff member(s) involved, and the broader practice team.^{23,24,27}

The physical severity of a violent incident does not necessarily correlate with the extent of the psychological impact on the recipient. Rather, it is the presence or absence of malice by the perpetrator that correlates with impact.²⁸

The psychological impact of both perceived and real threats can be considerable and cumulative²⁹ – manifesting as personal, professional, or social disturbances, including:

- poor concentration
- high levels of anxiety
- depression
- stress-related illness
- difficulty listening to patients
- avoiding certain patient types
- absenteeism
- diminished productivity
- diminished staff satisfaction
- high staff turnover
- difficulty recruiting
- reduced participation in the medical workforce
- social withdrawal.^{30,31}

1.5 Personal safeguards

To lessen the negative impact of patient-initiated violence and protect themselves in future, healthcare professionals reportedly:

- set limits on acceptable behaviour
- talk about the experience or treat it humorously
- seek social support from peers who demonstrate concern and listen to their account of events
- change their current practices – no longer making house calls, referring patients to hospitals or other public facilities after hours
- learn self-defence techniques to prevent future injury or escape the perpetrator.

1.6 A practice-wide systems approach to patient-initiated violence

While some GPs and practice staff may be highly experienced and effective at routinely resolving conflict and de-escalating aggression, this ability is not universal.

Often, it can be difficult for practice staff to determine when anger is escalating to the point of violence, and how to respond appropriately to different types and levels of violence.

A standardised (practice-wide) risk and incident management system can help GPs and their practice teams respond to patient-initiated violence in a planned, consistent and coordinated manner.

Systems thinking takes into account:

- all contributing factors in a practice environment
- interactions between all contributing factors
- dynamic changes that occur over time
- strategies required for risk and incident management
- associated roles, responsibilities, accountabilities and resources
- the need for a collaborative response.

The remainder of this guide outlines strategies that can help:

- prevent and manage aggressive/violent patient encounters (section 2)
- prepare and support the practice team (section 3)
- create a safe practice environment (section 4).

When considering the various strategies described in sections 2, 3 and 4, it's important to reflect on their appropriateness in terms of:

- the type and level of risk
- the frequency and severity of the patient's behaviour
- the patient's ability to understand the issues associated with their behaviour
- the patient's capacity to modify their behaviour
- previous attempts to resolve the matter
- the associated medico-legal risks and responsibilities.³²

Section 5 outlines a range of medico-legal issues associated with implementation of each strategy.

If in doubt about your medico-legal standing in relation to any scenario, always contact your medical indemnity insurer.

2. Patient-centred intervention strategies

Numerous human, task-related and contextual factors increase the risk of patient-initiated violence occurring during a patient encounter. The more factors that come into play, the harder it is to manage patient interaction effectively. However, being aware of the risks and common management strategies can significantly improve the dynamics of the situation. First, we consider some of the risks.

2.1 Assessing the risks

Cumulative stress

Where possible, be receptive to signs of cumulative stress. This includes emotional states such as grief, fear, distress, anxiety, acute or chronic pain, combined with other unanticipated events such as long waiting times.

Social context

Sometimes difficult behaviour can be associated with a patient's social context. Be mindful of potential language barriers, communication difficulties, cultural misunderstandings, complex/distressing family relationships, or friends and family members who may place the patient, or practice team, at risk of harm.

Difficult past encounters

Difficult past encounters with healthcare services can predetermine a patient's response to the perceived risk of similar events occurring in future. This may include having experienced:

- restraint or seclusion in the past
- refusal of requested drugs/treatment
- removal of privileges or belongings
- separation from family/friends
- no access to smoking areas
- treatment delays.

Past history of violence

A past history of violence is a major predictor of future violence. Where possible, ascertain whether the patient has a past history of escalating aggression or harm towards themselves or others.

Underlying medical condition

Look for evidence of an organic cause or comorbidity that might explain obvious signs of aggression. For example, cerebral insult (stroke, tumour, seizure, encephalitis, meningitis, trauma), hypoxia, hypoglycemia, sepsis, metabolic disturbances (hyponatraemia, thiamine deficiency, hypercalcaemia) or organ failure can trigger behavioural disturbances. The clinical scenario will determine the extent of investigation required.

Mental illness

Poorly treated or untreated mental illness can increase the risk of patient-initiated violence. However, it is important not to further stigmatise people with mental illness.

Most people who are mentally ill do not display violent behaviour.³³ In fact, people with mental illness are more likely to be victims rather than perpetrators of violence^{34,35} and suffer from the complications of violence, such as:

- post-traumatic stress disorder (PTSD)
- anxiety
- depression
- drug/alcohol misuse
- suicide.^{36,37}

Evidence of a psychiatric illness commonly includes/relates to a past history of mental illness; current medications; general physical appearance, including self-neglect; inappropriateness of mood, level of engagement, manner and content of speech; posture; movement; and drug use or alcoholism.

Psychosis and dual diagnosis

When making an assessment of mental health, it is important to bear in mind that some people, with certain types of mental illness and comorbidities, are more likely than others to engage in violent behaviour.^{38–40} They should be immediately recognised and assertively managed by a multidisciplinary healthcare team, either voluntarily or involuntarily as appropriate.

The common profile of a person in this subgroup is a young person with active delusional psychosis (usually schizophrenia), persecutory symptoms and disorganised thinking, who is abusing alcohol or other drugs.⁴¹

In these cases, the patient is usually lacking insight, resistant to engagement, non-compliant with treatment and socially isolated.⁴² Persecutory thoughts should be explored fully for violent intent toward self or others – particularly if there is a delay in getting treatment.⁴²

Due to the increased risk of violence occurring, psychosis needs to be viewed as a medical emergency – potentially requiring involuntary treatment of a patient. Further information about involuntary treatment can be found in Appendix 1.

Further evidence suggests that early medical intervention is associated with an improved prognosis, while a delay in treatment usually results in severe lifelong disability.⁴³

Alcohol and other drug intoxication or withdrawal

Patients intoxicated by alcohol and/or other drugs (AOD) can pose a serious threat to GPs and their practice teams.⁴⁴

Symptoms of alcohol intoxication include ataxia, slurred speech, emotional lability and disinhibition. Symptoms of alcohol withdrawal include anxiety, agitation, tremor, nausea, abdominal cramps and vomiting.⁴⁵

Drug-intoxicated patients can present with a wide range of symptoms. As the effects wear off, a patient may present with withdrawal symptoms such as:

- anxiety or jumpiness
- shakiness or trembling
- sweating
- nausea and vomiting
- insomnia

- irritability
- fatigue
- loss of appetite
- headaches.⁴⁶

In severe cases, withdrawal from drugs can be life-threatening and involve hallucinations, confusion, seizures, convulsions, acute ischaemic events or hypothermia. These symptoms can be dangerous and should be managed by a physician specifically trained and experienced in dealing with addiction.⁴⁶

GPs and practice staff should exercise extreme care with patients who are intoxicated or experiencing withdrawal symptoms. If safe to do so, issues to consider include:

- prompt identification of the intoxication or withdrawal
- management of associated clinical symptoms
- minimisation of associated complications
- stabilisation of physical and psychiatric conditions
- engagement of the patient in treatment.⁴⁷

GPs and other health professionals should seek further information on the management of patients with addictions to AOD, including information on:

- screening
- comorbidity
- assessment
- brief interventions
- treatment options and efficacy
- challenging behaviours
- motivational interviewing
- pain management
- poly-drug use
- pregnancy
- referral and shared care.

Some useful resources have been included in section 7 of this guide.

Drug-seeking behaviour

Drug-seeking behaviour broadly refers to patients falsely reporting symptoms to obtain prescription medicines for maintenance of drug dependencies or other nefarious purposes.

There is a wide spectrum of drug-seeking behaviours – many will not be obvious during the consultation. Common behaviours are included in Table 2.1.

Types of behaviour	Examples
Typical requests and complaints	<ul style="list-style-type: none"> • Aggressively complaining about need for medication • Asking for specific medications by name • Asking for non-generic medication • Requesting to have medication dose increased • Claiming multiple pain medicine allergies • Anger or irritability when questioned closely about pain
Inappropriate self-medicating	<ul style="list-style-type: none"> • Taking a few extra, unauthorised doses on occasion • Hoarding medication • Using a controlled substance for non-pain relief purposes (eg to enhance mood, sleep aid) • Injecting an oral formulation
Inappropriate use of GP services	<ul style="list-style-type: none"> • Visiting multiple doctors for controlled substances (doctor shopping) • Frequently calling the clinic • Frequent unscheduled clinic visits for early refills • Consistently disruptive behaviour when arriving at the clinic • Consistently calling outside of clinic hours or when a particular physician is on call who prescribes controlled substances
Resistant behaviour	<ul style="list-style-type: none"> • Unwilling to consider other medications or non-pharmacologic treatments • Frequent unauthorised dose escalations after being told it is inappropriate • Unwilling to sign controlled substances agreement • Refusing diagnostic work-up or consultation
Manipulative or illegal behaviour	<ul style="list-style-type: none"> • Claiming to be on waiting list or unable to afford dental work and needing to manage dental pain • Obtaining controlled substances medications from family members (including stealing from older relatives) • Using aliases • Forging prescriptions • Pattern of lost or stolen prescriptions • Selling medications • Obtaining controlled substance analgesics from illicit sources
Other typical behaviours	<ul style="list-style-type: none"> • Being more concerned about the drug than their medical problem that persists beyond the third clinic visit • Deterioration at home or work or reduction of social activities because of medication side effects

Source: The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, part A: Clinical governance framework. Melbourne: RACGP, 2015; p. 63. Available at www.racgp.org.au/download/Documents/Guidelines/Addictive-drugs/Addictive-drugs-guide-A.pdf [Accessed 14 September 2015].

GPs and practice staff should exercise extreme care with patients who have a known drug dependency and try to obtain licit drugs.

If no immediate danger is perceived, GPs should not provide small amounts of medication to the patient just to 'get rid of them'. For further information about possible ways of responding to drug-seeking behaviour, see Appendix 2.

If GPs and staff do feel threatened by a patient, especially someone who is affected by AOD and is seeking a prescription, they should consider giving the patient what they want and asking them to leave immediately to avoid a possible violent incident. Do not confront the patient. Always call the police and your state/territory drugs and poisons unit in this situation. For further information about state/territory drugs and poisons units, see Appendix 3.

Iatrogenic dependence

Some drug-seekers have genuine medical problems and have (or are developing) an iatrogenic dependence.⁴⁸ A patient with a valid therapeutic need for drugs of dependence should have a principal medical practitioner to manage their medication regimen and any developing dependence. Concurrent prescribing by other doctors might be detrimental to the patient.

Before prescribing a drug of dependence, a GP must take all reasonable steps to:

- ensure a therapeutic need exists
- ascertain the identity of a patient
- ascertain whether the medication requested has been prescribed by another healthcare provider.

If you are not in immediate danger, and suspect that a patient might be seeking more medicine than they need to treat a genuine medical condition, you can contact Medicare Australia's Prescription Shopping Information Service (PSIS) for more information about the patient's recent prescription history. More information about Medicare's PSIS can be found in Appendix 4.

2.2 Identifying warning signs of escalating aggression

Violence rarely 'comes out of the blue'. It is commonly preceded by behaviour that indicates a potential for violence.

However, sometimes it can be difficult to determine when anger is escalating to the point of violence, and how to respond appropriately to different types and levels of violence. The warning signs of escalating aggression include:

- veiled and overt threats to GPs, staff, or other patients
- violent gestures such as pointing, swearing, verbal abuse, slamming objects (eg doors, chairs)
- either intense staring or avoiding eye contact (this often depends on cultural background)
- increased psychomotor activity – restlessness, repetitive movements, pacing, arousal, and inability to sit still
- refusal to communicate, withdrawal
- harmful, violent thoughts and disordered thinking about violence
- past history of violence.⁴⁹⁻⁵¹

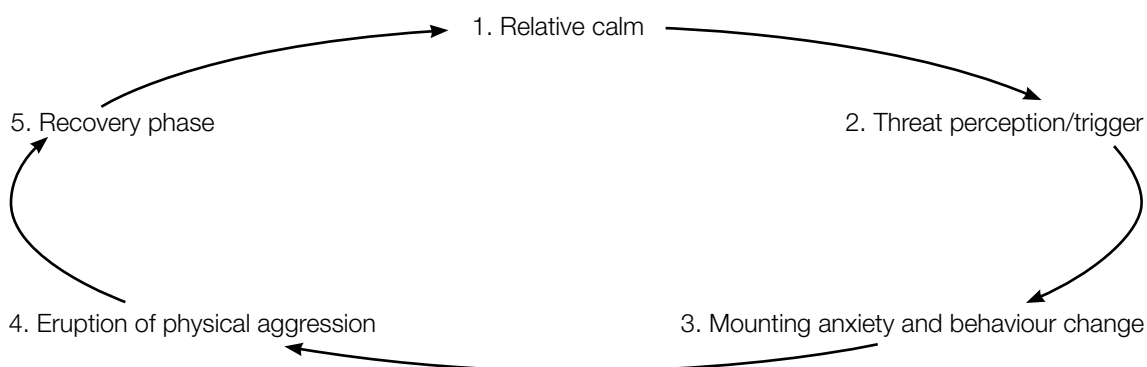
2.3 Anticipating the cycle of aggression

Once early warning signs of aggression have been detected, it is important to anticipate and recognise the different stages of aggressive behaviour in case things start to escalate.

Retrospective reviews of incidents of aggression reveal a pattern of sequential events. It is useful to consider this pattern as it may assist in evaluating and appropriately responding to both perceived and real threats.

The sequence of events is represented schematically in Figure 2.1 as a repeating cycle with distinct stages based on work previously carried out by Breakwell.⁵²

Figure 2.1. The cycle of aggression



Stage 1: The individual is at rest. There may be a heightened state of alertness.

Stage 2: The individual perceives internal and external cues as threatening – this could be a cue from the environment, staff or other patients. The person may misperceive internal cues, such as their own anxiety surrounding a medical condition.

Stage 3: There is a significant increase in central nervous system activity as anxiety escalates. Attempts to relieve anxiety are displayed as restlessness, hyper-vigilance and verbal abuse.

Stage 4: The individual feels increasingly threatened and vulnerable. High anxiety and discomfort are released through physical aggression.

Stage 5: Recovery phase – an individual's physical and emotional response may be below their normal baseline calm.

A patient in stage 1, 2, 3, 4 or 5 may continue to be very dangerous but may be amenable to discussion and/or negotiation. It is imperative that the threat continues to be treated seriously, even when the patient's aggression has settled.⁵

2.4 De-escalating aggression

If you believe you are not in immediate danger, you may find the following steps helpful in de-escalating aggression:

- **Appear calm, respectful, self-controlled and confident.** Think 'stay cool and professional'. This may be easier said than done, especially when an individual is screaming at you or using abusive language.
- **Use reflective questioning where you can.** Put the person's statements into your own words and then check to see that you have understood. By repeating or reflecting a person's message in the form of a question, you will give them the opportunity to clarify the message. Engage in conversation; acknowledge concerns and feelings, and let the patient know you are listening – for example, 'You need to see a GP as soon as possible, is that correct?'
- **Watch the way you speak.** If you are not in immediate danger, be clear and direct in your language – clearly explain your intentions. Avoid jargon and complicated choices. A person who is losing control cannot process complex information. Complex questions will increase anxiety and can make behaviour more difficult to manage.
- **Watch your body language.** As the person becomes increasingly agitated they will pay less attention to your words and more attention to your body language. Be aware of your space – maintain as much physical space as possible. Avoid too much eye contact as this can promote excessive outbursts in some people.

- **Embrace silence.** Surprisingly, silence can be a very effective non-verbal intervention. Silence on your part allows the individual time to clarify his or her thoughts. It can provide valuable time to reassess the situation.⁵³

If the patient is amenable to reason, try these additional verbal de-escalation techniques:

- **Portray your actions as being in the patient's best interest.** Do not portray your reason for action as being in your own or the practice's best interests – this can be inflammatory.

By portraying your suggestions or actions as being in the patient's best interest, an angry patient is more likely to undertake a 'cost-benefit' analysis of your suggested change rather than automatically dismiss your suggestions as oppositional or unacceptable.

- **Use a sequence of 'yes' questions.** It is very hard to remain angry with someone who you keep agreeing with. An effective technique to attempt to de-escalate aggression is to ask a sequence of questions to which the patient can only answer 'yes'.

The most effective way to undertake this technique is to do short summaries of the patient's perceptions and views as expressed to you with questions at the end such as 'Have I got that right?' or 'Is that what you mean?' A sequence of five or six questions where the patient is answering 'yes' is a powerful way to increase the likelihood that that an aggressive patient will see you as being on their side, even if they remain angry about the issue.

- **Maintain a solution focus.** This technique involves asking the aggressive patient to solve the problem they are concerned about by identifying as many solutions as they can think of to address the problem.

By simply listing the options they generate rather than arguing about the pros and cons of each option, there is the potential to stretch the person to develop hybrid or compromise options that are more acceptable to both parties.

Anger is usually associated with 'black and white/all or nothing' thinking. Hence, the skill of non-responding to the initial 'black and white' options and respectfully pushing the patient for more (often greyer) options can be very effective.

By calmly acknowledging that everything is an option, and stretching the patient for alternatives, a different conversation can be moulded. It is very difficult to remain in an aggressive frame of mind if you are engaged in a process of basic problem-solving.^{54,55}

2.5 Requesting support

The presence of another person can be enough to defuse a threatening situation. If you do not feel you are in immediate danger but require assistance, you can unobtrusively alert other staff to your need for support by potentially using:

- a speaker phone and key word(s), which when used out of context signal the need for assistance
- a telephone extension number reserved for distress calls
- a reliable computer pop-up message – activated at the press of a button.

2.6 Responding to the threat of violence

2.6.1 Personal protection

If you feel unsafe, act on your gut feeling and consider:

- activating a duress alarm if installed
- asking the aggressor to leave, and/or
- immediately leaving the room and alerting other staff to the perceived risks.

For those who are appropriately trained and understand the associated legal boundaries and duties, evasive self defence can at times help staff safely remove themselves from a threatening situation when:

- retreat is blocked
- all other non-physical strategies have failed
- the person is under threat of attack, or is being attacked.

However, the degree of force used must be proportionate to the degree of potential harm and must not be applied for longer than is reasonably required to control the risk of harm.⁵⁹

2.6.2 Immediate team response

Faced with a potentially violent situation, a practice team should have an emergency response policy and procedure (ERPP) in place to follow. All staff should have assigned roles/responsibilities and be trained to perform related tasks. The entire practice team should have prior experience collectively rehearsing the practice's emergency response and know who is ultimately in charge. An ERPP should include information about:

- the number of staff members required to respond to an emergency situation
- delegated roles and responsibilities
- the designated response leader/coordinator
- staff training requirements
- when and how to seek police involvement
- the evacuation protocol
- operational review and debriefing
- testing and maintenance of the duress alarm (if installed)
- relevant documentation.⁵⁷

More information about duress alarms can be found in section 4.7.2 of this guide.

2.6.3 Immediate post-incident response

Immediately after an incident, a range of actions may be taken that include:

- ensuring everyone is safe
- providing first aid and medical attention as required
- providing practical and emotional support as required
- reporting what happened to the relevant authorities as required
- preserving physical and other forms of evidence
- completing the relevant documentation.⁵⁶

Further information about incident reporting, debriefing, investigation and implementation of future safeguards can be found in section 3 of this guide.

2.7 Flagging patient health records

A history of violent behaviour remains the single best predictor of future violence.⁵⁸ However, information about history of violence is not always readily available in healthcare settings, thus limiting the extent to which staff can be forewarned about a potentially violent encounter.

As a general rule, practices should flag the health records of patients who demonstrate aggressive or violent behaviour or who are at risk of violent behaviour. There are both formal and informal means of flagging patient files and appointment systems.

Where in use, practices should have an agreed policy in place for file flagging. The policy should include:

- clearly defined criteria for file flagging
- a clearly articulated purpose for use of a flag (eg to protect the health and safety of treating staff)
- a standard procedure for flagging patient health records that makes the information readily available to those who need it
- a clearly defined scope of who has access to the information (eg treating practitioner only, restricting access to such staff on a 'need to know' basis)
- a mechanism to review flagged files to ensure ongoing relevance.⁵⁹

Such a policy would form part of the policy and procedure manual described in section 3.5 of this guide.

2.7.1 Flagging patient health records and anti-discrimination laws

While anti-discrimination laws may sometimes influence the steps that can and should be taken to deal with patient-initiated violence, they do not specifically prohibit the flagging of health records. Anti-discrimination laws also do not require GPs and their practices to tolerate or accept criminal acts.

To comply with anti-discrimination laws, GPs and their teams need to take a common sense and proportionate response to perceived or actual threats, taking into account the relevant factors for the patient, the practice and other people involved.

Further information about the application of anti-discrimination laws to the management of patient-initiated violence in a practice setting can be found in section 5 of this guide.

2.7.2 Flagging patient health records and defamation laws

Whatever form of flagging patient records is used, the information contained in the records needs to be clinically and factually accurate. This is particularly important given that patients have statutory rights of access to 'their' health records, and some patients may seek to argue that the flagging in some way has unlawfully defamed them.

Further information about the application of defamation laws to the management of patient-initiated violence in a practice setting can be found in section 5 of this guide.

2.7.3 Flagging patient health records and privacy law

The flagging system, and any communications about the patient either within the practice or beyond it, also needs to comply with confidentiality and privacy laws.

Further information about the application of privacy laws to the management of patient-initiated violence in a practice setting can be found in section 5 of this guide.

2.8 Issuing formal warnings

In the event of inappropriate behaviour by a patient, the treating GP or other practice staff should explain to the patient that their behaviour is unacceptable and what is expected of them in future. Ideally, this explanation should be provided in the presence of a witness.

The issued warning must also be documented in the patient's healthcare record with details of:

- the incident that triggered the warning
- any medical condition, medication, or other factor that contributed to the incident
- the issued warning – including an explanation of the expected behaviour
- the consequences of any future incident.

This should be signed by the witness and a letter should be sent to the patient reiterating what was verbally conveyed. See Appendix 5 for a proforma warning letter.

Any procedure to be followed by practice staff would form part of the policy and procedure manual described in section 3.5 of this guide.

Further information about the medico-legal issues associated with the management of patient-initiated violence in a practice setting can be found in section 5 of this guide.

2.9 Using acceptable behaviour agreements

An acceptable behaviour agreement indicates that although a patient has acted unacceptably, the practice team is willing to continue a therapeutic relationship with the patient, provided the patient complies with the conditions outlined in the agreement.

Acceptable behaviour agreements (otherwise known as doctor–patient contracts) can be a useful tool to modify behaviour.⁶⁰ However, health practitioners should note that acceptable behaviour agreements are not suitable for universal application. The context in which they have been found to be effective is in clinical settings that have the following characteristics:

- a proportion of patients suffer from drug/alcohol abuse–related conditions, drug-seeking behaviours or mental instability

- the practitioners who use such agreements are highly experienced in dealing with patients that have drug/alcohol addictions and related conditions, or mental instability
- the circumstances are such that the patient can be persuaded that there is a trade-off, beneficial to them, in agreeing to modify behaviour as a condition of continuing treatment.

While the utility of acceptable behaviour agreements has support, agreements are not always appropriate and are more likely to trigger aggression where:

- the practitioner is inexperienced in dealing with patients that have drug/alcohol addictions and related conditions or mental instability
- recourse to an acceptable behaviour agreement is an overreaction to a trivial incident
- an emergency situation exists.

It is recommended that where an acceptable behaviour agreement is used, it is introduced as follow-up to a letter indicating that the provision of care by the practice will cease if the unacceptable behaviour continues. Even then, caution needs to be exercised and medical staff need to give careful consideration to the likely risks.

Where possible, an acceptable behaviour agreement should:

- be a written agreement
- be tailored to the actual behaviour observed in the individual
- establish clear boundaries
- inform the patient of the consequences of stepping outside the boundaries set out in the agreement (eg termination of the doctor–patient relationship except in an emergency)
- establish a review process.⁶¹

The stated consequences of stepping outside the set boundaries need to be things that the practice can and will carry out. In this context, it is important for the practice team to be in agreement with their practice's acceptable behaviour agreement policy.

The behavioural demands imposed by the agreement need to be reasonable, rather than unfair, excessively burdensome or disproportionate to the risk. The procedure to be followed by practice staff should form part of the policy and procedure manual described in section 3.5 of this guide. See Appendix 6 for a sample acceptable behaviour agreement.

Further information about the medico-legal issues associated with the active management of patient-initiated violence in practice settings can be found in section 5 of this guide.

2.10 Improving safety of after-hours care

To ensure the safety and security of staff, practices need to have effective mechanisms in place to ensure GPs, locums or medical deputising services providing after-hours services are promptly informed of patients who are at risk of demonstrating violent behaviour.

GPs providing care outside normal working hours also owe it to themselves to make sure systems are in place to ensure their safety and security. Safety procedures to be followed after hours by practice staff would form part of a policy and procedure manual such as that described in section 3.5 of this guide.

Visit www.racgp.org.au/standards/114 for the RACGP *Standards for general practices* related to after-hours care, and see section 5 of this guide for further information about privacy, confidentiality, discrimination and defamation issues associated with warning others.

2.11 Improving safety of home visits

Practices also need to have effective mechanisms in place to ensure the safety and security of staff providing home visits. The procedures to be followed by practice staff would form part of the policy and procedure manual described in section 3.5 of this guide. A number of key considerations for inclusion are described below.

2.11.1 Practice strategies

Consider the following practice strategies for safer home visits.

- Ensure documented procedures are in place and followed, particularly when staff feel at risk, unexpectedly change plans, or are delayed.
- Education is very important – make sure all members of the practice team understand practice policy and procedure for home visits and include safety as part of the induction process.
- If possible, keep a database of all patients who have special management instructions and divert all patients who are flagged to receive alternative after-hours care.
- Where possible, flag patient files to ensure staff are warned if they are likely to be unwelcome at the home, or if the patient (or their family) has a known history of violence. This gives GPs the opportunity to alert police before making the visit or choose not to attend (and make alternative care arrangements such as an ambulance).
- Keep a record at the practice of the registration numbers, makes, models and colour of each staff member's car.
- Ensure all staff are routinely offered the use of a chaperone for home visits.
- If your practice engages a deputising service, it is essential you alert the service regarding high-risk patients.
- Ensure procedures are in place and followed if staff cannot be contacted or do not return/check in as expected.⁶²

2.11.2 Personal safeguards

Consider the following personal safeguards for safer home visits.

- Do not agree to provide a home visit before triaging the patient to assess their need for a home visit.
- Do not accept calls from patients threatening suicide or domestic violence, who are aggressive in their own language, or who are not known to the practice. Where possible, it is advisable to request new patients come into the practice.
- Do not visit patients requesting specific pain relief medication or repeat prescriptions if they are not known to you. Advise them to come to the practice or go to a hospital emergency department.
- Always think in advance about the situation you may be walking into – you can effectively manage a good percentage of potential personal safety problems just by anticipating them and being mindful.
- Make sure more than one person knows where you are going, including the patient's name and address and what time you expect to return.
- When speaking to the patient, ask them about parking – can you use the driveway, could someone move their car to make room for yours?
- Always park your car so it is pointing in the direction of the exit, so you can leave quickly if you need to.
- If parked in the street, park your car under a street light, lock the doors, and check the back seat before unlocking your car on return.
- Do not put a sign on your car indicating that you are a doctor.

- If it is dark when you arrive at the house, call while you are in the safety of your car and ask to have the outside lights turned on. If you can hear a dog barking, make sure it is secured.
- Always walk on the light side of the street; stay away from bushes.
- If you have to use a lift, make sure to stand by the control panel so you can control the lift and get out if you need to.
- Keep your bag close to you at all times; do not leave it unattended.
- Never become complacent. Be alert.

2.11.3 Questions to ask yourself before attending a home visit

- Is this a regular patient of the practice?
- Will it be dark when I arrive?
- Do I have a working torch?
- Are the streets well lit?
- Will I be walking along any deserted streets to get to the house?
- Am I visiting a block of flats?
- Do the lifts work?
- Will other people be around?
- Where are the nearest shops/places to escape in an emergency during the night?
- Do I feel safe and, if not, why not?
- Am I visiting alone?
- Am I carrying a personal alarm/mobile phone? Is it charged?
- Do I have the patient's phone number in my phone?
- Who knows where I am going?
- Do I have a system in place for reporting back to the practice or home?

2.11.4 The tipping point

The 'tipping point' in the escalation of violence refers to the point at which things have gone too far. In the situation of a home visit, it may be helpful to have prepared 'get out' phrases such as:

- 'So sorry, I left something in the car'
- 'My phone is vibrating – it'll be the service switchboard operators' (or whatever phrase is appropriate to your after-hours arrangements).

Once you have left the house, it is inadvisable to go back in. What made you take this action in the first place is unlikely to have changed appreciably.

Do not go and retrieve your doctor's bag. These are replaceable items that can be retrieved at a later date with a police escort. Move away from the house. Drive around the corner and call your 'alert' person.

Did an offence (physical violence) occur? Offences should be reported to the police.

2.11.5 Narcotics policy for home visits

- Leave narcotics locked in the boot of your car, preferably in a locked box.
- Only in the most extenuating circumstances (eg palliative care) should you write prescriptions for narcotics, and only after all reasonable steps have been taken to verify the identity of the patient.
- Do not routinely prescribe Schedule 8 substances or other addictive medications, including benzodiazepines, when providing home visits.*
- Some patients have their own supply of narcotic drugs from their usual doctor and request administration by a GP after hours. These patients will fall into two categories: the management of acute pain or the management of chronic pain.
 - In the case of acute pain management, a letter from the patient's usual doctor authorising narcotic administration is not sufficient unless it is very recent (within a few days) and refers to short-term use only. Letters should be closely checked to establish that they are genuine.
 - In the case of chronic pain management, patients may have a doctor's letter that is not recent. The patient's usual GP needs to provide a management plan for chronic pain patients and a copy of their drugs and poisons permit.

If you feel compromised in any way, leave the patient's house without administering treatment. If personal safety is at risk, give the patient whatever they want and leave immediately.⁶³

Source: Adapted from Levy M, editor. Don't be a hero/staying safe. QA&CPD Program. Melbourne: Melbourne Medical Locum Service, 2007.

*Schedule 8 refers to Schedule 8 of the Australia-wide Standard for the Uniform Scheduling of Drugs and Poisons. Schedule 8 drugs (or controlled drugs) are 'Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence'.⁶⁴ Examples of Schedule 8 drugs include methadone and morphine. See RACGP *Standards for general practices*, criterion 5.3.1, for further information on storage of Schedule 8 drugs – available at www.racgp.org.au/standards/531

2.12 Stalking

Stalking is a common form of violence against GPs and requires early intervention and special attention.

Legal definitions of stalking vary in Australian states and territories. Some jurisdictions require the accused to have engaged in a course of conduct before an offence is considered to have occurred. Some jurisdictions have expansive, but non-exhaustive, lists of the type of conduct that will amount to stalking or harassment, including:

- following, loitering near, or approaching a person
- loitering near, watching, approaching or entering a place where the victim lives, works or visits
- keeping the victim under surveillance
- telephoning, sending electronic messages to, or otherwise contacting the victim or any other person
- interfering with, threatening or hiding property in the possession of the victim
- giving offensive material to the victim or any other person, or leaving it where it will be found by, given to, or brought to the attention of the victim or another person
- stopping, confronting or accosting a person in a public place
- forcibly hindering or preventing any person from working at or exercising any lawful trade, business or occupation.

2.12.1 Personal safeguards

If being stalked by a patient, consider the following personal protective strategies.

- Document every contact with the stalker, including telephone calls, emails, letters and deliverables.
- Record all cases of being followed by car, on foot, or being watched. The documentation provides evidence that you have been stalked.
- Have a practice telephone with a caller identification screen. Log all calls from the stalker, recording the time, date and nature of the call (eg 'heavy breathing').
- Contact the police every time the stalker makes contact. The police should also keep documentation. Ask for a copy of the police log.
- Request that the local police assess the security of your practice.
- Change your home phone number to an unlisted number and only provide it to people who need to know.
- Advise your co-workers, friends, family and neighbours of the situation and ask them to watch for any unusual activity near your home, workplace or vehicle.
- Keep the outside of your practice and home well lit and free of too many bushes that might provide a stalker with a place to hide.
- Install extra locks, deadlocks, window security, floodlights, security screens and door alarms in your practice and at home.
- Never enter into a conversation with the stalker. Most stalkers are very personable and persuasive and are able to solicit a reply.
- Consider enrolling in a self-defence class.
- Vary your routine. For example, go home by different routes at different times and arrive at work at different times.
- If you travel by public transport, plan your trip to avoid excessive waiting times at public transport stops.
- If/when leaving your vehicle, ensure you are not being followed.
- Support from the practice is crucial if the stalking occurs at or near work.
- Apply for an intervention order against the stalker.

2.13 Applying for a protection order

In circumstances where there is a continuing threat of violence or intimidation against persons or property damage, you may need to consider seeking a protection order – otherwise known as an intervention or restraint order. The purpose of a protection order is to protect the safety of the victim.

The effect of the protection order is to restrict the perpetrator's behaviour in relation to the victim. In some circumstances, the order may also restrict the perpetrator's ability to go near the vicinity of the victim's place of work or residence. Orders can be obtained without disclosing the victim's address.

The legislation governing intervention orders varies from state to state and territory. Generally, if you have a concern about continuing threatened violence, this should be raised with the police and their assistance sought in obtaining a protection order at the time of the complaint and followed up if necessary.

Protection orders are generally granted only if a court is satisfied that it is necessary to restrict the perpetrator's future behaviour in relation to the aggrieved person.

A protection order limits certain types of behaviour – for example, what a person can do, or where they can go.

A protection order may prevent the perpetrator from:

- behaving offensively toward the aggrieved person
- approaching (or going near) an aggrieved person
- attending a premises where an aggrieved person lives, works or frequents
- being at a particular location
- contacting, harassing, assaulting, stalking, threatening or intimidating an aggrieved person
- damaging property owned by an aggrieved person
- causing another person to engage in conduct that is prohibited by the intervention order.

Protection orders, whether interim or final, are court orders and it is a criminal offence for a person to breach any of the terms of an order. If a respondent breaches an order, victims are advised to call the police. The respondent can be arrested without a warrant, or summoned to appear in court, be prosecuted and face maximum fines, or periods of imprisonment.

Application processes and forms of protection vary from state to state and territory. It is beyond the scope of this guide to provide detailed advice in relation to the law in each jurisdiction; however, an overview of the key processes and sources of additional information are provided in Appendix 7.

2.14 Discontinuing care where safety concerns exist

A practice may consider discontinuing care to a patient where genuine safety concerns exist as these may prevent GPs and practice teams from providing ongoing high-quality care. If a practice is considering discontinuing care to a patient, it needs to reflect on the situation of the GPs, their practice team, and on the patient.

A practitioner is not compelled to continue a treating relationship with a patient where the practitioner is unwilling to do so. In terminating the relationship, caution should be exercised in emphasising to the patient the need for continuing care, if there is such a need.

To consider what is reasonable under these circumstances, it may be useful to:

- ask yourself the question: ‘What would my peers say and do in this situation?’ Would your peers understand and support your choice to discontinue care if they were in the same situation? If you believe they would, this supports your decision
- reflect on the patient’s situation, especially any short-term risks to their health in discontinuing care. It can be useful to consider what action your peers would consider appropriate to meet the patient’s health needs.

If a delay in treatment would harm the patient, it is important to explain (if practicable) this to the patient. You may need to:

- advise the patient of the importance of getting care
- advise the patient of an appropriate place to get care, other than your practice
- act to reduce imminent harm to the patient (eg treating them in an emergency and/or calling an ambulance).

Doctors have an ethical responsibility to ensure that administrative staff do not turn away patients with urgent medical problems without reference to a doctor. Furthermore, doctors have an ethical duty to assure themselves that a patient does not have a life-threatening emergency before the patient is declined immediate attention or referred to another practice or hospital.⁶⁵

You may also need to consider the risks to other people (eg other patients who come to the practice) and factor this into your decision to discontinue care.

In a non-emergency situation where the relationship with the patient is terminated, the GP must:

- ensure the patient understands that the relationship has been terminated
- where possible, propose a realistic way for the patient to seek continuing general practice care.

If it is appropriate to talk with the patient face-to-face, carefully consider the way you tackle this discussion. Also ensure the practice is prepared for the discussion and any subsequent course of action.

If it is more appropriate to send the patient a letter advising them that you are discontinuing their care, the letter should:

- outline the boundaries you are setting (eg the patient is not to call or attend the practice)
- make an offer to transfer a copy of the patient's health information to a new practice with the patient's permission.⁶⁶

The procedure to be followed by practice staff should form part of the policy and procedure manual described in section 3.5 of this guide. See Appendix 8 for a sample letter to discontinue care.

When developing practice policies and procedures for discontinuing care, be mindful of the medico-legal frameworks that apply. For example, anti-discrimination laws come into play when discontinuing care. Patients cannot be excluded on the grounds of illness (including mental illness) or disability. However, anti-discrimination laws do not require GPs and their practices to tolerate or accept criminal acts.

2.14.1 What else do you need to do?

- Keep a detailed factual report in the patient's health record at the time the decision to discontinue care was conveyed, including a copy of any letter sent to the patient. This should be completed contemporaneously.
- Agree upon the practice's response to a violation of the boundaries you have set (eg what the practice will do if the patient calls or attends).
- Be aware that you are legally and ethically bound only to treat a person in an emergency situation.
- If you hold any concerns regarding the process of discontinuing care, notify your medical indemnity insurer.⁶⁷

Occasionally, a medico-legal challenge can arise when seeking to terminate a relationship in a way that still discharges the duty of care owed to the patient. When in doubt as to your rights and duties, you should contact your medical defence insurer.

Further information about duty of care and the application of anti-discrimination and negligence law to the management of patient-initiated violence in a practice setting can be found in section 5 of this guide.

2.15 Warning others

Making the decision to notify a third person can sometimes pose difficult legal (and occasionally ethical) questions. Among the legal challenges is having the ability to separate issues such as:

- confidentiality/privacy – when do you have the right to breach patient confidentiality to warn the relevant people/authority?
- duty of care/negligence – when, if ever, do you have a legal duty to warn a third person/authority?

This course of action raises some complex legal issues and is therefore discussed in section 5 of this guide.

3. Preparing and supporting the practice team

The safety and security of the practice team is the responsibility of all staff and the employer. It is important to create a practice culture where staff feel comfortable to speak up when they identify a potential problem or feel unsafe. Practice staff are well placed to identify risk factors and work with the practice team to generate practical solutions.

3.1 Assessing the risks

Risk factors for healthcare teams include:

- insufficient priority and accountability for OHS
- a culture of accepting OHS risk
- resources not always being available for staff to comply with OHS policy and procedure
- inadequate information and training provided to staff and managers
- lack of policies and procedures for prevention, early detection, crisis management and post-incident response
- cumulative stress, such as inadequate breaks, being tired and overworked, hampering the capacity of staff to notice signs of agitation
- ineffective communication between practice staff and the patient (and their family/carers).^{68,69}

3.2 Occupational health and safety

The potential exposure to patient-initiated violence in a general practice poses an OHS risk.

Further information about OHS laws and responsibilities can be found in section 5 of this guide.

3.3 Practice culture

Workplace culture is an important determinant of how individuals, and the practice as a whole, respond to instances (and the consequences) of workplace violence.⁷⁰ For example, adverse consequences can be exacerbated by a lack of support by the practice team.⁷¹ In contrast, the emotional impact of violence can be alleviated by the presence of a supportive and communicative environment.⁷²

Some GPs have expressed the view that patient-initiated violence may represent a failing on their part, akin to a lack of professional expertise or competence.⁶⁹ This may, in part, explain why GPs and their teams frequently display a higher tolerance for aggressive behaviour in their practice environments than they would tolerate in their personal lives.

Hence, it is important to create a culture where staff:

- feel confident expressing their anxieties regarding patients and are assured that these anxieties will be acted on – this allows for the early recognition of patients who may be potentially violent and validates the concerns of staff
- do not accept threatening behaviour as a ‘normal’ way of working or ‘just part of the job’
- have adequate breaks to attend to physical needs (eg lunch) so that their ability to notice and respond to threatening behaviour is not compromised.⁷³

3.4 Staff induction and training

Research has identified a reduction in the incidence of patient-initiated violence where staff are trained to take the appropriate preventative or responsive measures.

Formal training also ensures that all staff have the risk or incident management skills needed to fulfil their respective roles and responsibilities as part of a practice-wide risk/incident management system.

Training in the prevention and management of patient-initiated violence should ideally be delivered as part of a practice's induction process for all new staff, including students and trainees. Refresher courses should be available to all staff thereafter.

Preliminary training should focus on the prevention of patient-initiated violence. This might include an exploration of common risk factors, warning signs and the cycle of aggression, along with a range of risk mitigation strategies.

Staff can subsequently be trained to respond appropriately to aggressive or violent situations with an understanding of the associated medico-legal risks and responsibilities.

Other considerations for inclusion in a staff training program are familiarisation with:

- the practice's risk/incident policies and procedures
- relevant legal issues and legislative frameworks
- the practice's system of emergency response – including post-incident procedures and types of support
- local issues that may affect an incident response (eg access to support from others or outside services).⁷⁴

3.5 Policy and procedure

Section 2 explored a number of strategies for formal management of patient-initiated violence during the patient encounter. The associated procedures to be followed by practice staff would form part of a practice's policy and procedure manual for the prevention and management of patient-initiated violence. This would serve as a handy reference and educational resource for the entire practice team. Such documents typically contain:

- definition of patient-initiated violence
- statement of the aims of the policy
- statement of responsibility on the part of the general practice as an employer
- commitment to preventive measures that protect employees from aggressive and violent behaviour
- commitment to encourage incident reporting and to support staff following an incident
- commitment to consult and communicate with all stakeholders
- reference to the relevant OHS legislation and supporting guidance (eg WorkSafe)
- explanation of the policies and procedures that should be followed under different circumstances
- identification of those responsible for ratifying, implementing, monitoring and evaluating performance of the policy and associated systems and processes
- reference to risk/incident management training programs available to staff
- expectations and responsibilities of staff
- reference to all relevant legislation
- key contact information
- date of policy and date of review.

3.6 Incident reporting

Violence in general practice and other healthcare settings has a history of being seriously under-reported.⁷⁵

Reporting of a violent episode is influenced by many factors, including:

- severity of the injury – the more severe the injury, the more likely the GP or practice staff will report it
- legal responsibilities, including those of employers – ‘external’ violence, such as an armed hold-up, is a criminal matter and almost always is reported
- the propensity of an individual to report – the GP or practice nurse may feel a sense of obligation to continue treatment for the patient
- staff that see low-level violence or aggression as part of the job
- concerns raised by GPs about the impact of privacy law.^{5,76}

Criteria for incident reporting should be included in a practice’s patient-initiated violence policy and procedure manual. Consideration should also be given to the appointment of a ‘go-to’ person if/when a near-miss or violent incident occurs.

This process could be supported through the careful and appropriate use of a risk/incident register or logbook. Such tools can help practice staff monitor the prevalence/patterns of violence and a practice’s responsiveness for safety improvement purposes.

Note: There are a range of potential medico-legal implications associated with the use of risk/incident registers and logbooks; therefore, contact your medical indemnity insurer before commencing use.

3.7 Debriefing

The effects of violence in the workplace are serious. When there is an incident involving patient-initiated violence, it is valuable to provide staff with the opportunity to debrief. Debriefing serves three primary functions:

- provides an opportunity to share their experience with others and diffuse the impact of violence
- allows staff to receive emotional support and resolve personal issues that may have arisen from the incident
- provides an opportunity for the whole practice to ‘intellectualise’ the situation and review what happened from a quality improvement perspective.⁷⁷

Depending on the severity of the violence and cohesion of the practice team, debriefing may be provided by an external psychologist or a member of the practice team. The opportunity to consult an appropriate health professional, external to the practice, should also be offered to all staff members.

3.8 Investigation

The most effective way to prevent a recurrence of a violent incident is to review/investigate incidents as they arise and implement safeguards as appropriate. Physical violence does not need to be the trigger for an incident investigation. Any behaviour that makes a staff member feel threatened warrants review.

Following an incident of aggression or violence in the practice, there is value in bringing together a diverse practice team to review what occurred. Each staff member should reflect on what happened from their own point of view, as influenced by their position in the workplace.

Questions to consider when investigating a near-miss or violent incident include:

- What happened?
- What factors may have triggered the violence?
- Could the incident have been prevented?

3.9 Identifying potential safeguards

To develop clearly articulated safeguards, focus on a system breakdown rather than on the individuals involved. Safeguards do not need to be complex or expensive to be effective. This facilitates the development of diverse safeguards and barriers to minimise future incidents.

As part of the investigation process, consider asking: what safeguards or barriers can be put in place to minimise a recurrence? In particular, the practice team could discuss:

- management of agitated patients in the waiting room
- staff training in de-escalating aggression
- protocols around the use of duress alarms
- systems for flagging patient files
- relationship with your local mental health crisis assessment and treatment team (CATT)
- chaperoning during consultations.

3.9.1 Prioritising safeguards

Once the review is finalised, it is likely that the practice will be left with a range of possible safeguards or solutions. It is important to prioritise these. Be mindful that it is not always feasible or desirable to implement them all.

One way to establish priorities is to use an ‘ease-impact analysis’. For this analysis, a four-quadrant diagram is represented in Figure 3.1(a), with each square representing ‘ease’ and ‘impact’.

Figure 3.1(a). Ease/impact analysis

EASY to do Has LITTLE IMPACT	EASY to do Has HIGH IMPACT
HARD to do Has LITTLE IMPACT	HARD to do Has HIGH IMPACT

Using this diagram, solutions can be evaluated in terms of their ease of implementation, as well as their potential for impact. Solutions that are easier to implement and have high impact are stronger priorities than those with less ease or impact. A worked example appears in Figure 3.1(b).

Figure 3.1(b). Ease/impact analysis – Worked example

EASY to do Has LITTLE IMPACT <i>The practice manager writes a crisis response for the practice, but staff are not yet oriented to the crisis plan</i>	EASY to do Has HIGH IMPACT <i>Flag the medical record of patients who have a past history of violence</i>
HARD to do Has LITTLE IMPACT <i>Duress alarms installed in all consulting rooms, but staff are not yet trained in responding to duress signal</i>	HARD to do Has HIGH IMPACT <i>Ensure all consulting rooms have two exit points</i>

In setting priorities for change, ask: 'What does it really take to implement the safeguards needed to improve our systems?' This includes thinking about the way people in the practice may react to the proposed changes:

- Does someone have a lot invested in the way things work at the moment?
- Does someone have a strong opinion about the potential changes?
- Think about the benefits for each person, and put yourself in their position, and ask: 'What's in it for me?'
- Who needs to take action to make the change a reality?
- Who needs to be aware of the change? How can you make them aware of it? Do you have regular staff meetings where this information is conveyed?
- Does the change need to be reflected in the practice policy and procedures manual? Who is responsible for making sure this happens?
- How and when will you 'iron out' any wrinkles if the change does not work the way you intended, or does not achieve what you want?

3.10 Monitoring outcomes following implementation

When a change has been implemented, it is important to review:

- what worked, and why
- what did not work, and why
- whether the change is sustainable
- alternatives that can be trialled.

3.11 Effective relationships with local police and others

An important aspect of a prevention strategy is developing relationships with local police. They can identify potential risk factors and provide advice around securing the practice environment.

It can be useful to have effective referral arrangements with local mental health, domestic violence, child protection and AOD services. This can reduce uncertainty and related anxiety for patients who need referral to these services. It is also helpful to share the care of patients at risk of violent behaviours and to manage them as part of a multidisciplinary team.

It is important to have the contact details of key local services available, such as:

- police – in emergency situations dial 000
- local police station – in non-emergency situations
- drug and alcohol services
- mental health CAT services
- local hospital
- neighbouring medical practices and allied health services.

Checklist – the GP and practice team

- The practice has policies and procedures in place to manage and respond to patient-initiated violence and a duress alarm.
- All staff have received training regarding all of the practice's policies and procedures.
- The practice uses clinical meetings and case conferences to discuss a practice-wide approach to patients who present a safety risk (eg where there is a history of inappropriate behaviour, the patient's file is flagged if ongoing care is being provided).
- Practice staff notify a GP or practice nurse promptly if a patient arrives under the influence of alcohol or other drugs, just as they would notify the GP of other risk factors such as chest pain or difficulty breathing.
- At least one staff member, in addition to the GP, is present when the practice is open for routine consulting – this includes onsite after-hours consulting. For further information, visit www.racgp.org.au/standards/412 for the RACGP *Standards for general practices*, criterion 4.1.2.
- Consulting rooms close to reception are used after hours and on weekends.
- Practice security arrangements are covered in the induction of all new GPs, practice staff and medical students.
- The practice team acknowledges and acts on the safety concerns raised by reception staff (and other staff as relevant) before taking a patient into the consulting room.
- The practice has a policy that encourages practice staff not to go into a consulting room with someone who they have concerns with.
- The practice team is trained in 'people management', enabling staff to:
 - spell out their expectations of behaviour within the practice (establish ground rules) early and clearly
 - recognise and attempt to assist 'difficult' patients
 - prevent, control and 'de-escalate' violent situations within their role in the practice.
- All practice staff are confident to disclose uncomfortable feelings or episodes that concern them. Unless this occurs, a perception can arise that inappropriate behaviour is a 'one off', when in fact it has happened to other people in the practice.
- Reception staff are encouraged to call the police when necessary.
- Staff are escorted to car parks after hours – this could be two staff leaving together.

4. Creating a safe practice environment

Every aspect of the practice environment has a significant influence on the behaviour of patients, staff and others. In order to prevent and manage aggression, practice staff need to work in a well-designed and carefully considered environment.

However, environmental design as an isolated approach is not sufficient to address all security issues, and due consideration should be given to the vital role of practice staff in preventing and responding to aggression.

A balance needs to be achieved between maintaining a relaxed and inviting environment and facilitating smooth delivery of services, and ensuring safety of staff and other patients. This balance will be different for every practice depending on the nature and degree of existing risks.

4.1 Assessing the risks

Common environmental risk factors include:

- poor waiting area facilities (eg insufficient space, waiting area not visible from reception area)
- poorly designed consulting rooms (eg patient chair blocks the exit door)
- insecure storage of Schedule 8 drugs (eg stored in a way that makes them accessible to patients, such as samples being visible in consulting rooms)
- absence of functioning duress alarms
- poorly selected after-hours consultation rooms (eg using upstairs consulting rooms or rooms away from reception area after hours)
- poor lighting (eg poorly lit corridors, poor external lighting in the car park and surrounding property)
- insecure car parking.

4.2 Crime prevention through environmental design principles

This section is focused on crime prevention through environmental design (CPTED). CPTED is a formally recognised criminological construct aimed at enhancing those aspects of building design that discourage violence and aggression in the workplace.⁷⁸

CPTED involves identifying conditions in the physical and social environment that create opportunities for violence to occur in a workplace.⁷⁹ Identified risks are minimised through design (or re-design) of the practice and its immediate surrounds in ways that reduce opportunities to commit violence.⁸⁰

CPTED strategies are usually comparatively cost effective compared to the economic loss from acts of violence in the practice, which may include damage to property, days lost to staff on leave and high staff turnover.⁸¹

One of the main criticisms about CPTED is the need to strike a balance between securing the workplace, practicality and aesthetics. Excessively overt security can create a fortress-like mentality and is not particularly welcoming to either patients or practice staff.

4.3 Site-specific environmental strategies

Environmental strategies are most effective when they are tailored to site-specific risks in an individual general practice. Site-specific strategies include:

- placement of effective barriers to control access to certain areas
- design of waiting areas making all patients visible to practice staff
- removal of all objects that could be easily thrown (eg to assault staff with)
- minimisation of perceived waiting times by providing distractions (eg views to a garden or water feature)
- consulting rooms with increased visibility and duress alarms.⁸²

4.4 Schedule 8 drugs

- Don't store Schedule 8 drugs in the consulting room.
- Store Schedule 8 drugs in a locked cupboard in an area inaccessible to patients.
- Ensure the source of the medication supplied is not visible.
- Avoid leaving patients unattended in the treatment room where Schedule 8 drugs may be accessed by the patient.
- Keep supplies of prescription pads and letterhead paper locked up, except for the minimum required for the day. Both computer-generated and handwritten prescriptions are easily reproduced with today's technology.
- Keep additional stationary supplies locked up in an area inaccessible to patients.
- Avoid leaving patients unattended in consulting rooms or at reception where prescription pads and letterhead paper are accessible.

Further information is available from the RACGP *Standards for general practices*.

4.5 Effective barriers

Architectural or engineering design can control access to specific areas to deter a violent episode. For example, it can incorporate:

- sufficiently wide counters that are difficult for a person to lean over and strike or physically contact a receptionist
- a physical barrier between the reception area and consulting rooms to prevent unrestricted patient access to consulting rooms
- locks on cupboards where 'hot products', such as Schedule 8 drugs, are stored
- fencing to prevent practice grounds and the car park being used as public thoroughfares.

Good design can ensure that staff are safer while still ensuring access for people with disabilities.

Things to consider when designing a new front counter:

- the design of counters and desks should be determined by their purpose and the degree of risk associated with the tasks and work area
- counters should be sufficiently high to make it difficult for an adult to climb or jump over
- the floor height could be raised on the staff side so that employees are higher up than patients (this also minimises ergonomic risks to staff).⁸³

4.6 Waiting areas

Waiting areas need to be as comfortable and spacious as the existing space allows. When waiting times are identified as a contributor to the degree of risk, consider ways in which patients can be distracted while waiting.

Important considerations are:

- ventilation and temperature control
- adequate seating and a clear path to reception
- water dispensers and toilets
- ways to alter the perception of time spent waiting – reducing perceived waiting time can reduce anxiety and frustration (eg provide appropriate selection of reading material to keep patients occupied, or distractions such as views to an outside garden)
- clear signs and explanation for delays in appointments may reduce patient agitation
- a poster for the waiting room informing patients about expected behaviour at the practice (a poster for the waiting room accompanies this guide*)
- furniture being heavy enough that it cannot be thrown or used as a weapon.

*The poster accompanying this guide is designed for display in the practice waiting room. It is deliberately uncomplicated, sending a straightforward message.

This poster demonstrates the practice's attitude toward aggression and violence.

Be mindful that if you display this poster in your waiting room and choose not to act on behaviours that breach this position, you are sending a message to your patients that your practice does tolerate a certain level of threatening behaviour.

Before you display the poster, think about how your practice will respond if a patient demonstrates aggression or violence. Your response needs to be consistent.

4.7 Consulting rooms

There are a number of simple ways to improve the safety of consulting rooms.

- Arrange furniture to ensure the GP's chair is closest to a door, with no obstruction blocking the exit. When designing new consulting rooms, consider including two doors, allowing for two exit points.
- Furniture should be kept to a minimum and heavy enough that it cannot be thrown or used as a weapon.
- Consider arranging the consulting room desk to separate the GP and patient. See Appendix 9 for several diagrams (a–c) of effective design and layout options for consulting rooms.

Establish a system to alert other practice staff in an emergency. Some practices use:

- a speaker phone and single dial to reception that allows the GP or practice nurse to press one button and have the activity in the consulting room heard in reception
- a pop-up computer message, activated by pressing one computer key that alerts reception staff to the situation (this is dependent on reception staff observing the pop-up and responding)
- a key word that when used out of context alerts other staff to a dangerous situation.

4.7.1 Increased visibility

The careful design of a building, including internal and external surroundings, can increase visibility and act as a deterrent to aggression or violence.

'Natural surveillance' can help practice staff and patients monitor the safety of people at the practice. Perpetrators know they are more likely to be caught if visibility is increased. Simple measures may help modify their behaviour and act as a deterrent.

Examples include:

- good lighting and visibility in high-risk areas such as car parks, storage areas and corridors, especially during the evening and night hours
- positioning the reception desk so that staff working at it routinely look toward the doors of consulting rooms
- using consulting rooms that are close to reception after hours and on weekends – this may mean using a room in which you do not usually consult
- developing a clear policy that encourages staff not to go into a consulting room with someone they have concerns about
- installing visible duress alarms
- installing closed-circuit television.

4.7.2 Duress alarms

Duress alarms can be considered as part of the risk control response. They should not be considered on their own as the primary risk control mechanism; rather, they form part of an overall risk management approach.

If you have a security system installed, ensure:

- you have a routine for checking the battery back-up
- staff are aware of procedures for getting assistance and using the alarm
- staff response to the alarm has been standardised and rehearsed as far as possible to reduce confusion in an emergency.

4.7.3 Closed-circuit television

Some GPs working in high-risk areas have installed closed-circuit television (CCTV) in their waiting room (only) and a monitor in every consulting room. However, patient privacy must be considered if CCTV is in use, and a notice must be displayed in the waiting room and on the front door informing people that CCTV monitoring is in progress.

The presence of CCTV is itself an effective deterrent, while additional continuous monitoring (which in most cases places unrealistic time demands on staff) acts as a further safeguard.

Checklist – the practice environment

Some of the suggestions in the checklist below can be readily implemented in existing practices, while others (eg ensuring consulting rooms have two exit points) are more achievable during the design/building phase of a practice.

- Physical barriers are in place to prevent access by patients to working areas – patients cannot readily gain access to consulting rooms without passing reception.
- Reception counters are designed appropriately. Wider and higher counters at reception make it harder for patients to lean over and harm receptionists.
- Patient waiting area is comfortable, spacious and well lit.
- Furniture is heavy enough that it cannot be thrown or used as a weapon.
- Waiting room and consulting room signs are prominently displayed that notify the public that limited cash and drugs are kept onsite.
- Additional security measures (eg locks on storage cupboards) are in place where medications are stored or being distributed.
- Chairs in consulting rooms are arranged so the GP or practice nurse is sitting closest to the door. See Appendix 9 for ideas regarding layout of a consulting room.
- Where possible, consulting rooms have two exit doors.
- Duress alarms are installed (where practicable).
- CCTV is in use where appropriate (with prominently displayed signs where in use).
- Glass in windows and doors is shatter-proof.
- Security locks exist on all windows and access doorways.
- If appropriate, curved mirrors are placed at hall intersections to prevent patients from concealing their presence.
- Effective lighting exists in corridors, car parks, walkways and external surrounds of the building.
- There are no obstacles to good visibility on the ground outside the practice, such as bushes near the entrance, or tall hedges around the perimeter of the building.

The RACGP publication *Rebirth of a clinic: A design workbook for architecture in general practice and primary care* addresses many design considerations. This resource is available to purchase in hard copy from the RACGP at www.racgp.org.au/publications/ordering

5. Medico-legal issues

Introduction

General practitioners and those who work within general practice, as well as patients and their carers, must obey Australian laws. These laws include both the civil and criminal laws.

Sometimes, however, difficult medico-legal challenges arise – particularly when faced with patient-initiated violence. This is because the episode of violence has unfolded in a clinical setting, which imposes very specific legal and ethical duties upon the healthcare professionals.

This does not mean that GPs and their practice staff must therefore accept whatever comes their way. In fact, laws, including occupational health and safety laws, make it increasingly clear that that is not the case. Instead, they must broadly understand some of the potential medico-legal challenges and ‘traps’ that could cause problems for the unwary in seeking to appropriately respond to patient-initiated violence.

5.1 OHS responsibilities and injuries to workers or others

5.1.1 Australian OHS

Recently, there has been an agreed national approach towards OHS, through the introduction of model OHS laws. However, not all states have enacted these laws. Currently, OHS laws operate in the jurisdictions as shown in Table 5.1.

Table 5.1. Australian state and territory OHS laws	
Jurisdiction	Model legislation (or other)
Federal	<i>Work Health and Safety Act 2011</i> Work Health and Safety Regulations 2011
ACT	<i>Work Health and Safety Act 2011</i> Work Health and Safety Regulation 2011
New South Wales	<i>Work Health and Safety Act 2011</i> Work Health and Safety Regulation 2011
Northern Territory	<i>Work Health and Safety (National Uniform Legislation) Act</i> Work Health and Safety (National Uniform Legislation) Regulations
Queensland	<i>Work Health and Safety Act 2011</i> Work Health and Safety Regulation 2011
South Australia	<i>Work Health and Safety Act 2011</i> Work Health and Safety Regulations 2012
Tasmania	<i>Work Health and Safety Act 2012</i> Work Health and Safety Regulations 2012
Victoria	Not yet introduced (see <i>Occupational Health and Safety Act 2004</i>)
Western Australia	Not yet introduced (see <i>Occupational Safety and Health Act 1984</i>)

The legislation imposes obligations upon persons ‘conducting a business or undertaking’. This is very broadly defined and imposes a general duty of care to ensure the safety of workers and others in the workplace.

The duty extends not just to employees/workers but also to ‘other persons’. In both cases, the person conducting the business or undertaking must ensure, so far as is ‘reasonably practicable’, that those persons are not put at risk from work carried out as part of the business or undertaking. That duty also extends to self-employed persons (ie sole practitioners).

These OHS laws therefore impose an obligation on a person conducting a business or undertaking to identify and eliminate or control all risks associated with violence as far as is reasonably practicable. Staff also have a duty to take reasonable care to ensure that their acts are not harmful to the health and safety of themselves or others.

Similar obligations exist even in those jurisdictions that have not yet adopted the model laws. For example, in Victoria employers are required to provide and maintain, so far as is reasonably practicable, a working environment that is safe and without risks to health, including the psychological health and welfare of employees. Under that legislation, this duty includes the provision of:

- a safe physical environment
- safe systems of work
- adequate facilities for the welfare of employees
- information, instruction, training and supervision to enable employees to perform their work in a safe manner, without risks to health.

5.1.2 Workers compensation and employee injury

If an employer fails to meet their OHS obligations, injured workers can be compensated through OHS schemes or the statutory workers compensation schemes in each jurisdiction as shown in Table 5.2.

Table 5.2. Australian state and territory workers compensation schemes	
Jurisdiction	Title of workers compensation law
Federal	<i>Safety, Rehabilitation and Compensation Act 1988</i>
ACT	<i>Workers Compensation Act 1951</i>
New South Wales	<i>Workers Compensation Act 1987</i>
Northern Territory	<i>Return to Work Act 2015</i>
Queensland	<i>Workers Compensation and Rehabilitation Act 2003</i>
South Australia	<i>Workers Rehabilitation and Compensation Act 1986</i>
Tasmania	<i>Workers Rehabilitation and Compensation Act 1988</i>
Victoria	<i>Accident Compensation Act 1985</i>
Western Australia	<i>Workers Compensation and Injury Management Act 1981</i>

Sometimes, injured workers might also be able to obtain additional compensation through the courts via a common law negligence claim against their employer.

5.1.3 Growth in legislative offences for harming health professionals

In recognition of the increasing exposure of health professions to violence from patients and others, some governments have created specific offences dealing with that problem. For example, in Victoria, changes in 2014 to the *Summary Offences Act 1966* have made it an offence – punishable by a significant fine or imprisonment – to assault a health practitioner (s 51A).

Similarly, crime legislation in New South Wales provides for aggravating factors to be taken into account in determining the appropriate sentence for an offence to include where the victim was (among other occupations) a ‘health worker ... or other public official exercising public or community functions’ and the offence arose because of the victim’s occupation or voluntary work (*Crimes (Sentencing Procedure) Act 1999*, s 21A(2)).

5.1.4 Further information about state and territory OHS requirements

Each state and territory has its own government organisation responsible for the management of OHS schemes. Further information can be found at:

WorkSafe Victoria: www.worksafe.vic.gov.au

WorkCover NSW (New South Wales): www.workcover.nsw.gov.au

WorkSafe WA (Western Australia): www.commerce.wa.gov.au/WorkSafe

WorkCover Queensland: www.worksafe.qld.gov.au

SafeWork SA (South Australia): www.safework.sa.gov.au

WorkSafe Tasmania: <http://worksafe.tas.gov.au>

WorkSafe ACT (Australian Capital Territory): www.worksafe.act.gov.au

NT WorkSafe (Northern Territory): www.worksafe.nt.gov.au

5.2 Some particular medico-legal challenges

Sections 2, 3 and 4 of this guide outlined a range of practical strategies that can help general practices manage risks and/or violent incidents. This section focuses on the legal frameworks and challenges that constrain how each strategy can be implemented. Table 5.3 provides an overview of potential medico-legal considerations associated with different risk and incident management strategies.

Table 5.3. Risk/incident management strategies and associated medico-legal considerations		
Section of this guide	Recommended strategy	Potential medico-legal considerations
2.7	Flagging files of patients with a history of violent behaviour within a practice	Negligence Defamation Privacy/confidentiality Disability discrimination
2.8	Issuing formal warnings	Negligence (duty of care) Privacy Disability discrimination
2.9	Using acceptable behaviour agreements	Contact Disability discrimination
2.13	Applying for a protection order	Occupational health and safety law Various jurisdictional 'stalking' laws and procedures
2.14	Discontinuing care	Disability discrimination Ethical obligations (Medical Board of Australia Code of Conduct)
2.15	Warning others	Privacy/confidentiality Negligence (duty of care)
3.0	Preparing and supporting the general practice team before and after an incident	OHS law
4.0	Creating a safe practice environment	OHS law Disability discrimination Negligence

These and other legal considerations will be explored below focusing on how the following legal frameworks shape a general practice team's response to patient-initiated violence:

- privacy and confidentiality laws
- negligence law, and the duty you might owe to persons other than the patient
- defamation law
- discrimination law.

Note, however, that legal issues associated with the management of patient-initiated violence can often be highly complex and circumstance-specific. Where there is any doubt about a practice's (or a practitioner's) legal standing, the healthcare team's professional indemnity insurers should be consulted. They will be able to provide further medico-legal assistance. It is recommended that practices have a practice indemnity policy.

5.3 Privacy and confidentiality issues

The right to inform others about a violent or potentially violent patient is constrained by the treating healthcare team’s responsibilities under privacy law and confidentiality law.

Patients are owed a duty of confidentiality. They also have rights under privacy law. Their rights under privacy law govern the entire ‘health information lifecycle’ and are generally broader than the ‘traditional’ confidentiality rights.

Privacy laws must guide a practice team’s approach to sharing information with others about a violent, or potentially violent, patient without that patient’s consent.

5.3.1 Australian privacy and confidentiality law

All general practices must comply with the Commonwealth *Privacy Act 1988* as well as (where they apply) state and territory privacy laws set out in Table 5.4 below. Some of these laws deal with information privacy generally (not just health information), others have ‘dedicated’ health privacy laws (eg the Victorian *Health Records Act 2001*).

Table 5.4. Australian state and territory privacy laws

Jurisdiction	Legislation
ACT	<i>Information Privacy Act 2014</i>
New South Wales	<i>Privacy and Personal Information Protection Act 1998</i> <i>Health Records Information Privacy Act 2002</i>
Northern Territory	<i>Information Act</i>
Queensland	<i>Information Privacy Act 2009</i>
South Australia	Information Privacy Principles established by South Australian Privacy Committee
Tasmania	<i>Personal Information Protection Act 2004</i>
Victoria	<i>Privacy and Data Protection Act 2014</i> <i>Health Records Act 2001</i>
Western Australia	<i>Freedom of Information Act 1992</i>

For more information about privacy legislation in specific states and territories, visit www.oaic.gov.au/privacy/other-privacy-jurisdictions/state-and-territory-privacy-law

The privacy laws impose restrictions on the way information about patients can be collected, used (within the practice) and shared (outside the practice). Given the very broad definition of ‘health information’ in these laws, information about past or possible future patient-initiated violence is probably ‘health information’.

It is also important to note that the Commonwealth *Privacy Act* underwent significant amendment in 2014. As a result, a new set of Australian Privacy Principles (APPs) have replaced the old National Privacy Principles (NPPs). For more information on the changes and the APPs, visit:

- Privacy fact sheet 24: How changes to privacy law affect you, May 2014 www.oaic.gov.au/privacy/privacy-resources/privacy-fact-sheets/other/privacy-fact-sheet-24-how-changes-to-privacy-law-affect-you
- *Privacy Act*: www.comlaw.gov.au/Details/C2015C00451

In relation to the *Privacy Act*, refer to:

- Privacy fact sheet 17: Australian Privacy Principles
- APP guidelines

- Privacy business resource 2: *Privacy Act* reforms – checklist for APP entities (organisations)
- APPs and NPPs – comparison guide www.oaic.gov.au/privacy/privacy-topics/health-for-service-providers/resources-for-health-service-providers

The *Privacy Act*, and indeed any privacy legislation in Australia, emphasises the importance of:

- obtaining the consent of the patient before using and sharing information about them, unless there is a good, legally justifiable reason not to. When notifying about their violent behaviour, it is almost never practicable to seek their consent – see discussion below
- sharing information in a way that is privacy-respectful – that is, by sharing the minimum necessary information with the minimum number of, and most appropriate, people. In practice, this means the information disclosed should be factual, and limited to the minimum necessary to communicate the relevant details.

5.3.2 Privacy exceptions – When does the law permit you to share information about your violent/potentially violent patient?

So when is it possible to obtain, use and share information about actual, threatened or suspected patient-initiated violence? Privacy laws (and confidentiality laws) do recognise several exceptions. Below are the main exceptions to consider when trying to determine whether a proposed information sharing policy/practice is lawful.

5.3.2.1 The ‘serious threat’ exception

It is possible to collect, use and disclose information even without a patient’s consent for the purpose of lessening or preventing a serious threat to the life, health or safety of any individual, or to public health or safety (APPs 3.4(b), 6.2(c), 8.2(d) and 9.2(d)).

This law was changed in 2014 to remove the requirement that the relevant threat must not only be ‘serious’ but also ‘imminent’.

To rely on this exception, it is necessary to satisfy a number of critical elements:

- **Impracticable to obtain consent**

Before this exception can be relied upon, it is necessary to be able to point to one or more clear reasons that make it unreasonable or impracticable to obtain the patient’s consent. Relevant considerations may include:

- the nature of, and potential consequences associated with, the threat – for example, the urgency of a situation and level of threatened harm may require collection, use or disclosure before it is possible to seek consent
- the source of the threat – for example, it may be unreasonable to seek consent from the patient where they could reasonably be anticipated to withhold consent, or where the act of seeking their consent could increase the threat.

- **Reasonable belief that collection, use and disclosure is necessary**

It is also necessary to have a reasonable basis for concern, rather than simply an honestly held subjective belief, suspicion or concern.

Examples of circumstances that might create a reasonable basis include:

- the patient has a documented history of anger management problems or uncontrolled aggression
- the patient’s capacity for violence or aggression is associated with drug/alcohol dependency or mental illness such that speculation as to escalation of violence poses an unacceptable risk
- the patient’s behaviour prompting the report to police is sufficiently serious to cause alarm or threaten the safety of those witnessing the incident.

Also, information collection, use or disclosure must be ‘necessary’. It is not good enough for it to be merely helpful, desirable or convenient.

- **Serious threat**

There needs to be a serious threat to the life, health or safety of any individual, or to public health or safety.

Importantly, the exception does not apply – and disclosure cannot be justified – after the threat has passed. To justify disclosure, it is necessary to form a reasonable belief that the threat is ongoing and is ‘serious’ – one that poses a significant danger to an individual or individuals.

The likelihood of a threat being carried out as well as the consequences, if the threat materialises, are both relevant. A threat that may have dire consequences, but is highly unlikely to occur, would not normally constitute a serious threat.

The serious threat must apply to a threat to life, health or safety. This can include a threat to a person’s physical or mental health and safety. It could include a potentially life-threatening situation or one that might reasonably result in other serious injury or illness.

The threat may be to an individual the practice is dealing with, or to another person. It may also be a threat of serious harm to an unspecified individual, such as a threat to inflict harm randomly.

A ‘serious threat to public health or safety’ relates to broader safety concerns affecting a number of people. Examples include:

- the potential spread of a communicable disease
- harm, or threatened harm, to a group of people due to a terrorist incident
- harm caused by an environmental disaster.

5.3.2.2 Where there is no time to use the police and the risk to others is serious

Ordinarily, the ‘serious threat’ exception would, if relied upon, lead to contact with the police. But police assistance in contacting neighbouring practices may not be practicable in all instances, such as where a neighbouring practice needs to be urgently alerted to an imminent threat. Where there is genuine fear for the safety of another practitioner or neighbouring practice (eg it is believed that the patient has ‘targeted’ a specific doctor, person or practice), the following factors are relevant to consider.

- Is the danger imminent – likely to happen so soon that it is not practicable to wait for police involvement?
- Is it serious? (refer to the meaning of ‘serious’ above.) If so, identify which practitioners are particularly vulnerable and prioritise contact accordingly.
- Is contacting the police alone going to be inadequate, given the imminence of the risk/threat?
- When telephoning or emailing other practitioner(s), what is the minimum amount of information necessary to put them on notice and on guard? If possible, avoid giving the name of the patient to the other practice.

Notify the police as well, and tell the other practice that the police have or will be notified.

It is desirable for neighbouring practices to cooperate in formulating the most effective means of communication and to discuss concerns.

Consider taking the proactive step of telephoning local practice principals or medical directors and discussing the way local practices would respond if a serious threat were to arise in the future.

Also consider safeguards such as ensuring that local practitioners, who may need to act in a coordinated manner, have exchanged mobile phone numbers and email addresses.

5.3.2.3 Taking action where suspected unlawful activity or serious misconduct may have occurred

Another exception recognised under the *Privacy Act* is where there is reason to suspect that unlawful activity, or misconduct of a serious nature, that relates to the practice's functions or activities has been, is being or may be engaged in. And it is reasonable to believe that the collection, use or disclosure is necessary in order for the practice to take appropriate action in relation to the matter (s 16A(1)).

5.3.2.4 Reporting to the police (enforcement bodies)

Another relevant exception under the *Privacy Act* is where the practice reasonably believes that the use or disclosure of the personal information is reasonably necessary for one or more enforcement-related activities conducted by, or on behalf of, an enforcement body (APP 6.2(e)). 'Enforcement body' is defined to include Commonwealth, state and territory bodies that are responsible for policing and criminal investigations (eg the police).

To rely on this exception, the *Privacy Act* imposes specific obligations to make a written record of the relevant communication.

That written record could include:

- the date of the use or disclosure
- details of the personal information that was used or disclosed
- the enforcement body conducting the enforcement-related activity
- if the practice used the personal information, how the personal information was used by the practice
- if the practice disclosed the personal information, who it disclosed the personal information to (this may be the enforcement body or another entity)
- the basis for the entity's 'reasonable belief'.

This will help the practice assure itself that this exception applies, and it may be a useful reference if the entity later needs to justify its reasonable belief.

5.3.3 Exceptions to your confidentiality obligations

The law also recognises that sometimes confidentiality needs to be breached where there is an overriding public interest. In that situation, a doctor must decide whether their duty to the community outweighs that to their patient.

The legal scope of the public interest exception to the duty of confidentiality is often unclear. Always seek advice before relying on this exception.

5.4 Duty of care/negligence issues

The law of negligence requires the exercise of reasonable care to those whom a legal duty of care is owed. Clearly, that duty is owed to patients – even violent patients. Equally, a duty of care is owed to other patients who are visiting a practice and could become victims of violence.

A violent/potentially violent patient may seek to allege negligence in a range of situations. For example, the patient:

- might suffer harm (eg their condition worsens or becomes more difficult to treat) because of a delay in treatment arising from refusal to treat or termination of the therapeutic relationship.
- may allege that the aggression/violence was itself caused by underlying, undiagnosed or under-treated illness
- may, very occasionally, allege that because the doctor failed to recognise and manage an underlying mental health problem that caused the violence/aggression, the patient was involved in later violent conduct (and subsequent prosecution under the criminal law) for which the negligent doctor (rather than the mentally ill patient) should be responsible.

GPs and practice staff are not the only ones who owe a duty of care to patients. Patients also owe a duty to exercise reasonable care for their own safety. At law, a patient is expected to act reasonably – unless there is some illness-related reason that explains and justifies their ‘unreasonable’ behaviour.

5.4.1 The violent/potentially violent patient and your duty to third persons

What about third parties and the duties owed to them, particularly where those third parties are harmed or at risk of being harmed by a violent patient?

There are, potentially, many people outside a practice who might be injured by that practice’s aggressive or violent patient, in circumstances where it might be alleged that negligence (on part of the treating healthcare professional) was responsible for them suffering harm. These include:

- Healthcare professionals to whom patient care is transferred, once the original treating relationship is terminated. The duty of care question is whether the transferring doctor owes the new doctor a duty to warn about the patient’s violence/aggression.
- A related issue is whether the new doctor or their staff can sue the transferring doctor for a breach of that duty if in fact they are injured by that violent/aggressive patient in circumstances where the transferring doctor failed to put the new doctor on notice of that risk.
- Other healthcare professionals. This could be the other healthcare professionals involved in current or future treatment, or other GPs from whom treatment might be sought once a prior therapeutic relationship has been ended. This latter category is particularly problematic, as it is not necessarily confined to GPs in the immediate vicinity (whatever ‘immediate’ might mean).
- Other persons who might be harmed by the aggressive/violent patient, and who were not warned about the risk.

In all these situations, the crucial threshold question – at least so far as the law of negligence is concerned – is whether the transferring doctor owes a legal duty to these persons. If the answer is ‘yes’, then the next question is: what is the scope of that duty, and has the transferring doctor discharged it by exercising care that was reasonable in all the circumstances? To that extent, the law is easily stated. But in practice, it poses issues that are often very complex.

5.4.2 The Tarasoff case (does not represent Australian law)

Many will be aware of the American decision of Tarasoff, in which the responsible, treating healthcare professional was found to have owed – and breached – a duty of care to a third person in relation to the known violent propensities of their patient.

But Australian law probably goes in a different direction, and is quite complex. Critically, the authorities and commentaries (both local and overseas) that have reviewed Tarasoff and similar cases have generally only imposed a duty where there was a known, imminent risk to an identifiable person. In other words, the duty was held not to exist where there was only a theoretical, or possible, risk to a range of persons simply because the patient displayed violence/aggression in their interactions with their treating doctor or their staff.

The relevant law in Australia comes from both a number of important court decisions as well as various statutes that have been introduced since the turn of the century to achieve so-called ‘tort law reform’. The main statutes appear in Table 5.5. Note, however, that in some jurisdictions there have been multiple statutory enactments over time.

Table 5.5. Australian statutes introduced to achieve tort law reform

Jurisdiction	Key legislation
ACT	<i>Civil Liability (Wrongs) Act 2002</i>
New South Wales	<i>Civil Liability Act 2002</i>
Northern Territory	<i>Personal Injuries (Liabilities and Damages) Act 2003</i>
Queensland	<i>Civil Liability Act 2003</i>
South Australia	<i>Civil Liability Act 1936</i>
Tasmania	<i>Civil Liability Act 2002</i>
Victoria	<i>Wrongs Act 1958</i>
Western Australia	<i>Civil Liability Act 2002</i>

While there certainly are situations where a GP can be found to have owed (and breached) a duty to prevent a patient from harming a third person, they are rare.

5.4.3 Duty of care tests under statute and in the courts

Although the jurisdictions have not legislated uniformly, most have now adopted the position that a person is not negligent for failing to take precautions against a foreseeable risk, unless that risk is ‘not insignificant’ and a reasonable person in the same position would have taken precautions against the risk of harm. For example, the New South Wales *Civil Liability Act* (s 5B) describes the law in this way:

1. A person is not negligent in failing to take precautions against a risk of harm unless:
 - (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and
 - (b) the risk was not insignificant, and
 - (c) in the circumstances, a reasonable person in the person’s position would have taken those precautions.
2. In determining whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things):
 - (a) the probability that the harm would occur if care were not taken
 - (b) the likely seriousness of the harm
 - (c) the burden of taking precautions to avoid the risk of harm
 - (d) the social utility of the activity that creates the risk of harm.

Importantly, this statutory position largely reflects the circumstance-specific approach of the previous common law – that the existence of the duty will often depend on the specific circumstances. For example, if a patient has told their GP that they intend to kill their treating specialist and the treating GP believes they are serious, there is a significant chance that, as a matter of law, that GP needs to be seen to be responding to that real threat (eg by notifying the police) and that their failure to do so could expose them to a successful negligence claim if, through their failure to act, the threat is carried out. This is because, on these particular facts, the threat was real, significant and immediate and was directed to an identified individual made known to the patient's treating GP.

However, not all situations will necessarily generate that duty. The courts, when asked to consider these issues related to duty of care, have generally been cautious when seeking to extend the persons to whom a legal duty might be owed.

That caution reflects a number of concerns they have about extending the duty, including:

- imposing a legal duty where the direct cause is the criminal conduct of someone else (the violent patient) rather than anything their treating doctor did or failed to do
- the difficulty of confining the class of persons to whom a duty may be owed within reasonable limits.

This is a complex and evolving area of law. When in doubt, GPs should seek advice and guidance from their medical indemnity insurer.

5.5 Defamation issues

Another risk is that the patient might argue that the disclosure of information about their violent/abusive behaviour either within the practice or beyond it has unlawfully defamed them. The key is to ensure that the relevant communication (written or verbal):

- is accurate and truthful (truth is always a defence to any defamation complaint)
- communicates no more information than is necessary
- is confined to facts rather than opinions, speculation or rumour
- complies with privacy law and the exceptions recognised by it (see discussion on privacy in section 5.3)
- is communicated 'narrowly', only to those who need to know the information
- is justifiable: if what has been experienced was really only a one-off episode and unlikely to occur again, might it be inappropriate – and a disproportionate response – to mention it to anyone outside the practice?

This final point is particularly important. A patient who was involved in an isolated act of aggression – particularly where it arose because of a specific, one-off event/stressor/trigger – would not want to be unfairly 'tarred' with a reputation for violence where to label them as violent or having violent propensities is inaccurate and unfair.

Once again, and as with many issues explored in this chapter, caution and common sense needs to be exercised, and in a way that shows a basic understanding of the legal framework within which the laws of defamation now function.

For that reason, a brief description of the way the laws operate has been set out below, along with the defences that might be available where the patient alleges that disclosure of information about their alleged violence/aggression has defamed them.

5.5.1 Australian defamation law

Defamation law is now uniform throughout each state and territory in Australia. Material (both written and oral) is defamatory if it is likely to:

- injure a person's reputation, or
- injure a person in their profession or trade.

Whether material is defamatory involves determining what is meant by the material. Another way of putting this is to ask what 'imputation' the material conveys. Having identified those imputations, the next task is to assess whether the meaning satisfies the definition of what is defamatory.

In determining these issues, a court examines the natural and ordinary meaning of the words – how an ordinary person would interpret the material unaided by special knowledge.

5.5.2 Possible defences to defamation

The laws recognise that the need to protect reputation may sometimes be overridden by other, competing public interests.

For these reasons, several defences are available. For current purposes, the most relevant statutory defences are:

- **Justification (truth)**

One defence is that the defamatory imputations carried by a statement are substantially true.

'Substantially true' means true in substance or not materially different from the truth. A mere inaccuracy in detail that does not go to the substance of the imputation will not stop it from being substantially true.

- **Contextual truth**

Contextual truth is now available to defendants both for contextual imputations that are separate and distinct, and those that are substantially similar to the defamatory imputations the plaintiff complains about. The new defence is wider than was previously available. There is no public interest requirement.

- **Defence of honest opinion**

An honestly held (but wrong) opinion about the patient's violent propensities can be expressed, so long as it can be demonstrated that it was in the public interest for that opinion to be expressed. In order to rely on this defence, it must be proven that the:

- published matter was an expression of opinion rather than a statement of fact
- opinion relates to a matter of public interest, and
- opinion is based on proper material.

The uniform defamation legislation does not define what 'public interest' means, so this defence will rely on the court's interpretation of what is a matter of public interest. The common law has previously interpreted this as requiring a matter to relate to people in public office or within the public arena, performing public duties. That means that this defence:

- may extend to discussions with the police, but
- probably will not extend to discussions with other healthcare professionals.

However, for this particular defence to apply, the statement must be an honest statement of opinion or comment, not a statement of fact. The test is: would an ordinary reader consider the statement to be one of opinion or of fact?

This can be a surprisingly complex analytical area, involving the making of the most subtle and tortured intellectual distinctions.

Under the new laws, an opinion is based on 'proper material' if the material in question:

- is substantially true, or
- was published on an occasion of absolute or qualified privilege (either under defamation legislation or at common law).

5.5.3 Qualified privilege

For current purposes, qualified privilege protects the publication of material in the performance of a duty or to protect an interest. However, it only exists where there is a 'reciprocity' of duty and interest between the publisher and those to whom the material is published. That required level of reciprocity will probably exist in dealings with police, but not necessarily with respect to discussions between healthcare professionals in private practice.

5.6 Discrimination issues

Systems that identify and respond to patient-initiated violence are crucial. Where those systems are operating properly, that will sometimes mean that the violent/potentially violent patient is going to be managed differently from other, non-violent patients (eg by flagging patient records, imposing rules on an ongoing therapeutic relationship, terminating the therapeutic relationship).

Sometimes, however, that violence might be linked to, or caused by, a specific disability (psychiatric, cognitive, intellectual). Where that occurs, the treating team needs to be mindful of the impact of discrimination laws.

Discrimination laws will not stop a treating team from dealing with the violence, but they may need to shape – and sometimes limit – the approach taken.

Likewise, these laws do not mean that a patient with a disability is entitled to commit a crime (eg assault/battery) upon their treating team when others are not. This point was strongly made in a major High Court decision several years ago:

... there will be cases where criminal conduct for which the perpetrator would be held criminally responsible could be seen to have occurred as a result of some disorder, illness or disease [constituting a] disability within the meaning of the Act. It would be a startling result if the Act, on its proper construction, did not permit [persons covered under it] ... to require, as a universal rule, that employees and pupils comply with the criminal law.⁸⁴

Bad behaviour unrelated to a disability (even if the patient happens to have a disability) need not and should not be tolerated.

5.6.1 Australian discrimination law

The Federal *Disability Discrimination Act 1992* (DDA), as well as the various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics.

Further information is provided by the Australian Human Rights Commission at www.hreoc.gov.au. This website has guides to the relevant legislation and links to state and territory agencies with similar responsibilities.

The definition of 'disability' in the DDA includes:

- intellectual
- psychiatric
- neurological.

The DDA makes it against the law to discriminate against a patient because of their disability. That means one cannot:

- refuse to provide a patient services and access to facilities based on their disability
- provide services on 'less favourable' terms and conditions
- provide the services 'in an unfair manner'.

A key complicating factor is that importantly (and somewhat confusingly) the statutory definition of disability extends not just to the condition itself but also to the consequences of that condition. In particular, s 4(g) of the DDA includes within the definition of ‘disability’:

... the disorder, illness or disease that affect a person’s thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour.

In other words, it is unlawful to discriminate against a patient on the grounds of their disability, or the symptoms or manifestations of that disability. That symptom or manifestation might on occasion be violence.

These laws must inform and be reflected in a practice’s approach to managing patient-initiated violence, where (as might sometimes be the case) there are grounds to believe the violence is in some way linked to a patient’s disability.

5.6.2 Two types of discrimination

There are two types of discrimination under the DDA:

- **Direct discrimination** – it is discrimination under the DDA to treat a person less favourably because of his or her disability than a person without that disability would be treated in the same or similar circumstances.
- **Indirect discrimination** – this happens where the same treatment applies to people with and without a disability but the impact is to disadvantage or exclude people with a disability in a way that is not reasonable.

Indirect discrimination includes:

- where there is a condition, practice or requirement imposed on your patient before you are willing to treat them that may be the same for everyone, but which unfairly excludes or disadvantages people with disabilities in a manner that is unreasonable
- when you treat a patient unfavourably on the basis of a characteristic that applies generally to people who have such an impairment.

5.6.3 Management of the violent/aggressive patient, and direct discrimination

Where a patient with a disability complains that efforts to identify and manage patient-initiated violence are discriminatory, the usual focus will be on indirect discrimination – that is, that:

- the patient is treated or it was proposed that they be treated less favourably than the treating GP or staff would, in circumstances that are the same or not materially different, treat patients without that disability
- this was done because of the patient’s disability.

5.6.4 Defences

Anti-discrimination laws contain a number of exemptions, exceptions and defences. If they apply, an otherwise valid complaint of discrimination cannot be sustained. Exemptions, exceptions and defences in Australian anti-discrimination legislation include:

- ‘unjustifiable hardship’ in accommodating a person’s disability
- acts done to comply with other legislation, such as OHS legislation.

5.6.4.1 Unjustifiable hardship

A defence of 'unjustifiable hardship' may be available with respect to both forms of discrimination. The DDA does not define 'unjustifiable hardship' but rather states (s 11) that:

... in determining whether a hardship that would be imposed on person (the *first person*) would be an *unjustifiable hardship*, all relevant circumstances of the particular case are to be taken into account, including the following:

- (a) the nature of the benefit or detriment likely to accrue to, or be suffered by, any persons concerned;
- (b) the effect of the disability of a person concerned;
- (c) the financial circumstances, and the estimated amount of expenditure required to be made, by the first person [person claiming unjustifiable hardship];
- (d) the availability of financial and other assistance to the first person;
- (e) [in the case of the provision of services, or the making available of facilities] any relevant action plans given to the Commission under section 64.

The impact or potential impact on staff is therefore clearly a relevant consideration.

5.6.4.2 Indirect discrimination – reasonable in the circumstances

In addition, a defence to indirect discrimination, as noted above, is available where the differential treatment is 'reasonable'.

The case law establishes that the following principles are relevant to determining what is reasonable in the circumstances.

The test is objective and is less demanding than a test of necessity but more demanding than a test of mere convenience. A response to patient-initiated violence, therefore, will only constitute indirect discrimination if that response is shown not to be objectively reasonable having regard to the circumstances of the case.

Whether a requirement, condition or practice is reasonable depends on all the relevant circumstances of the case, including:

- the nature and extent of the disadvantage resulting from the imposition, or proposed imposition, of the requirement, condition or practice
- whether the disadvantage is proportionate to the results sought by the person who imposes, or proposes to impose, the requirement, condition or practice
- the cost of any alternative requirement, condition or practice
- the financial circumstances of the person imposing, or proposing to impose, the requirement, condition or practice
- whether reasonable adjustments or reasonable accommodation could be made to the requirement, condition or practice to reduce the disadvantage caused, including the availability of an alternative requirement, condition or practice that would still achieve the results but would cause less disadvantage.

The key issue is to understand that, occasionally, the violence/aggression arises from an underlying illness or disorder. Where that happens, not only the disorder but also its behavioural consequences constitute a disability at law, which in turn imposes certain obligations upon the practice.

More often than not these laws can be complied with by undertaking practices that display a commonsense, proportionate and 'reasonable' response to the perceived or actual threat – particularly when the alternatives involve an ongoing and intolerable threat to the safety and wellbeing of staff and other patients. It follows from this that an inappropriate or disproportionate response is not only (again) clinically inappropriate but is also legally dangerous.

6. Case studies and questions

Case study 1 – Jack

Jack, aged 18 years, is brought to your practice by his parents who are extremely concerned about their son's sudden deterioration in behaviour and recent physical assault on a fellow university student. They report he has been hearing voices. Today Jack appears agitated. He is pacing the room, and is withdrawn and uncommunicative with his parents. When the receptionist asks Jack to wait in a GP consulting room, he swears and pushes her against a wall.

One of the other staff members informs you of Jack's outburst. You note from Jack's patient file that he was also seen at your practice two weeks ago, at which time he slammed his fist on your colleague's desk after being advised of a three-month wait for an appointment with the local mental health service.

Question 1

What actions would you take to de-escalate Jack's violent behaviour?

Question 2

What are the risk factors for violent behaviour?

Question 3

What are the important questions to ask when eliciting Jack's history?

Question 4

What are some of the early or prodromal signs of psychosis?

Comment

It is very important to recognise psychosis early, as the patient is more likely to respond to treatment with anti-psychotic medication and to have a better prognosis in the long term.

Question 5

What are the criteria for admission of an involuntary patient to a psychiatric facility in your state or territory?

Comment

Jack's behaviour fulfils these criteria as he does not consent to treatment and is at risk of harming others.

Question 6

How would you conduct a debriefing session for your receptionist and other practice staff?

Further history

The practice team discusses the possibility of discontinuing a therapeutic relationship with Jack due to his aggressive behaviour. The team decides to continue care after he is discharged from hospital as he is unlikely to be at risk of violent behaviour after he has responded to treatment. They have discussed discharge planning with the mental health team. However, for their safety, they choose to insert an electronic warning flag in Jack's file. The warning flag appears on the screen each time an appointment is requested for Jack and the call is then managed by the principal GP. The practice implements a policy that indicates two staff must be present in the room during all future consultations.

Note: Discontinuing patient care will be covered in *Case study 3*.

File flagging systems

As a general rule, practices should flag the file of patients who demonstrate aggressive or violent behaviour, or who are at risk of violent behaviour, because a history of violent behaviour remains the single best predictor of future violence. However, in the healthcare setting, information about past history of violence is not always readily available, limiting the capacity to which staff can be forewarned about a potentially violent encounter.⁸

Question 7

What are the restrictions around flagging patient files when there has been a history of violence?

Case study 2 – Tania

Tania, aged 28 years, is holidaying with her extended family and is new to your practice. Apparently, you have been recommended as the best GP in the area. Tania says she has run out of her prescription for diazepam and oxycodone for her chronic back pain due to secondary cancer in her spine. You do not have any medical records, her solo GP in New South Wales is currently on long service leave, and you cannot contact him. When you begin to take a history, Tania starts to cry and says she can't sleep and will hurt herself 'unless you prescribe the benzos'. You begin to feel uncomfortable in the consulting room alone with Tania because of her assertive body language and the aggressive tone of her voice.

Question 1

What are some of the warning signs of escalating aggression?

Question 2

How could you respond to Tania's request for drugs of addiction in view of her escalating aggression, and in the absence of any other knowledge about her?

Question 3

Tania calms down as you call your practice nurse to the consulting room. What are the features of your history and examination?

Comment

Do not provide drugs of addiction to new patients unless you are able to confirm the history with the patient's usual GP or specialist. If in any doubt, consult with the drugs and poisons unit in your state or territory, or with specialist colleagues at a pain clinic or palliative care unit.

Question 4

How can you identify or report a patient who you suspect is prescription shopping?

Question 5

What would you do if you were physically threatened by Tania for drugs?

Question 6

How would you define assault?

Question 7

What steps can be taken to minimise the risk of patients obtaining access to Schedule 8 drugs, prescription pads and letterhead paper?

Case study 3 – Jonathon

Jonathon, aged 38 years, has visited the practice only twice before. He presents to you requesting a letter of good character for an upcoming court appearance for drink driving. You see from his medical record that he has a past history of alcohol and illicit drug use. When you ask about his current use, Jonathon answers irrationally and becomes highly agitated. He throws his chair at you and storms out of the consulting room, knocking down an elderly patient.

The practice team decides, for their safety, to discontinue a therapeutic relationship with Jonathon as his previous acceptable behaviour agreement has clearly failed (see Appendix 6).

Question 1

Outline the process of discontinuing care with a patient.

Further history

Despite your letter to Jonathon discontinuing care, over the next three weeks he contacts your practice by phone, abusing the reception staff several times a day. He tries to persuade the reception staff to schedule another appointment.

Question 2

When is it deemed appropriate to contact the police or a neighbouring practice about a person at risk of violent behaviour, and what information should be conveyed in the disclosure?

Comment

The assault on the GP and the elderly patient should be reported to the police. The general practice may wish to seek advice from local police in relation to Jonathon's potential risk to other practices.

Further history

Two weeks later, Jonathon is seen by reception staff waiting in your practice car park. The next day Jonathon is again in the car park, leaning against your car door. Jonathon shouts out to the reception staff that he'll wait for you in the car park all day if necessary.

Question 3

What should you do after being informed Jonathon is waiting in the car park?

Question 4

Stalking is a common form of violence against GPs and requires early intervention and special attention. What safeguards could be put in place to manage Jonathon's stalking behaviour?

Question 5

How do you take out an intervention order in your state or territory?

Case study 4 – Louise

You work in a nine-doctor practice that rotates the after-hours work, and this evening you are the on-call GP. Late in the afternoon you receive a call from Louise, aged 46 years, requesting a home visit. Louise is known to you; however, she usually comes into the practice. Louise tells you she has a severe muscle spasm in her back after an accident at work. After speaking with Louise, you agree to visit her early in the evening.

Question 1

What factors should you consider when triaging a patient for a home visit?

Question 2

What systems could the practice put in place to maximise your safety and security before attending a home visit?

Question 3

What personal safeguards could be put in place to maximise your safety and security on a home visit?

Further history

When you arrive at the house, Louise's 15-year-old son lets you in and directs you to the bedroom. Louise does not appear to be in pain.

While you are in the bedroom with Louise, her husband enters and verbally abuses you for taking so long to arrive. You feel threatened by his outburst and irrational reaction and notice he is blocking the doorway.

Question 4

What should you do immediately?

Case study 5 – Liz

While you are away at a house call, 35-year-old Liz unexpectedly attends your practice and demands to see you immediately. Your receptionist, Kathleen, is alone except for an elderly patient in the waiting room. The receptionist explains to Liz there are no available appointments this afternoon. Liz turns to the other patient and angrily demands the elderly lady give up her appointment. The elderly lady is frightened and doesn't answer Liz, which escalates her aggravation.

When the receptionist approaches Liz in the waiting room in order to protect the elderly lady from further verbal abuse, Liz swears and spits in her face. Liz proceeds to a consulting room, refusing to leave until you arrive back from your home visit.

The next morning Kathleen calls to say she is stressed and frightened, and cannot return to work until you provide a safe working environment. She intends to make a WorkCover claim and take at least four weeks' sick leave.

Question 1

What role do employers play in providing a safe work environment for employees?

Question 2

What could you do in your practice to be 'proactive' about providing a safe working environment for staff?

Question 3

What are the common sequelae of patient initiated violence for practice staff?

Question 4

What are some of the features of a safe physical environment?

Question 5

What changes could be made to the physical practice environment to minimise a future incident in the waiting area?

7. Practice and community-based activities

This section encourages you to undertake one practice-based activity and one community-based activity.

You are encouraged to use this guide, and engage with your colleagues to complete these activities.

When selecting an activity, consider the learning objectives you developed in the predisposing activity and choose an activity that assists you in meeting your learning needs.

Practice-based activity

Choose one practice-based activity from the following:

- Summarise what you have learned from this guide and give a presentation at a lunchtime practice meeting or journal club.
- Meet with reception, practice management staff and GPs in your practice. Share an incidence of patient-initiated violence or patient aggression that you experienced while working at the practice. Using the case studies as a guide, use this session to brainstorm whole-of-practice strategies for minimising the risks of patient-initiated violence.
- Write a patient education article for your practice newsletter on practice safety or a related issue. You could explain why it is that patients may be asked a number of questions before being able to obtain a home visit, or explain the practice policy on prescriptions for Schedule 8 drugs.
- Review the patient education material you have in your practice on any topic relating to this guide.
- Develop a resource folder of high-quality information and useful referral contacts in your local community, such as contact details of:
 - the police (emergency situations – dial 000)
 - the local police station (non-emergency situations)
 - drug and alcohol services
 - mental health CATT
 - the local hospital
 - neighbouring medical practices and allied health services.

This activity must involve at least two hours' time commitment and details must be submitted with your evaluation.

Community-based activity

Choose one community-based activity from the following:

- Contact another general practice in your area and find out (preferably by visiting their practice) what strategies, protocols and practice design features they use to minimise the risks associated with patient-initiated violence.
- Share with another general practice your strategies, protocols and practice design features.
- Consider the principles of CPTED. Invite local police officers or members of the police crime prevention unit to your practice to discuss security of the practice environment and identify areas for improvement. Use Case study 5, questions 4 and 5 to assist you.

- Facilitate a QI&CPD meeting on patient-initiated violence in your local area using the case studies, information and resources provided in this guide.
- Write an article for the local newspaper on a topic relating to this education module.

This activity must involve at least 90 minutes' commitment and details must be submitted with your evaluation.

Additional resources

- Cognitive Institute. Mastering difficult interactions with patients course. Available at www.cognitiveinstitute.org [Accessed 7 September 2015].
- Commonwealth of Australia. National guidelines on medication-assisted treatment of opioid dependence. Canberra: Department of Health, 2014. Available at www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/ng-mat-op-dep [Accessed 7 September 2015].
- Mayhew C. Preventing client-initiated violence – A practice handbook. Research and public policy series; no. 30. Canberra: Australian Institute of Criminology, 2000.
- National Centre for Education and Training on Addiction (NCETA) Consortium. Alcohol and other drugs: A handbook for health professionals Canberra: Australian Government Department of Health and Ageing, 2004. Available at www.health.gov.au/internet/main/publishing.nsf/Content/phd-aodgp [Accessed 7 September 2015].
- National Prescribing Service. Managing drug and alcohol problems in primary care. NPSNews 2002:22. Available at www.nps.org.au/__data/assets/pdf_file/0003/15798/news22_drugs_and_alcohol_0802.pdf [Accessed 14 September 2015].
- NSW Department of Health. Drug and alcohol psychosocial interventions: Professional practice guidelines. North Sydney: NSW Department of Health, 2008. Available at www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf [Accessed 7 September 2015].
- The Royal Australasian College of Physicians. Prescription opioid policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use. Sydney: RACP, 2009. Available at www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/CNMP-pdf.aspx [Accessed 7 September 2015].
- The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice. Melbourne: RACGP, 2015. Available at www.racgp.org.au/your-practice/guidelines/drugs-landing [Accessed 7 September 2015].
- Sim M, Khong E, Rispoli P, Wain T, Hendricks, Rudd C. Practice kit: Managing behaviours safely in general practice. Systems and Intervention Research Centre for Health, Joondalup, WA: Edith Cowan University & Osborne GP Network, 2008. Available at www.ecu.edu.au/schools/nursing-and-midwifery/research-activity/projects/managing-behaviours-safely-in-general-practice/practice-kit/related-content/downloads/practice-kit.pdf [Accessed 17 September 2015].
- Sim M, Hulse G, Khong E. Acute pain and opioid seeking behaviour. *Aust Fam Physician* 2004;33:1009–12. Available at www.racgp.org.au/afp/200412/14263 [Accessed 7 September 2015].
- Sim M, Hulse G, Khong E. Back pain and opioid seeking behaviour. *Aust Fam Physician* 2004;33:431–35. Available at www.racgp.org.au/afp/200406/14723 [Accessed 7 September 2015].
- Sim M, Khong E, Choy W, Casey W. Substance abuse: check program of self assessment. Unit 428. Melbourne: The Royal Australian College of General Practitioners, 2007.
- State Government of Victoria. The adult AOD screening and assessment instrument: Clinician guide. Melbourne: Department of Health, 2013. Available at www.turningpoint.org.au/site/DefaultSite/filesystem/documents/AODresources/Clinician%20Guide%20050713.pdf [Accessed 7 September 2015].
- Steer N, editor. General practice management toolkit. Melbourne: The Royal Australian College of General Practitioners, 2014. Available to purchase from the RACGP at www.racgp.org.au/publications/orders [Accessed 7 September 2015].

8. Reinforcing activity

Write answers to the following questions.

1. How would you define patient-initiated violence?

2. Do you consider the risk of patient-initiated violence to be 'part of the job'?

3. What would you do if a patient became aggressive during a consultation?

4. How would you manage the situation of a patient requesting benzodiazepines or other drugs of addiction?

5. Under what circumstances would you undertake a home visit for a new patient, or a patient requesting specific analgesia, or a patient previously known to behave aggressively?

6. Would you refuse to treat a patient who became aggressive?

7. If so, how would you go about terminating the therapeutic relationship?

8. What features of consulting room and practice design may improve the physical safety of staff?

9. What medico-legal considerations are associated with different types of intervention?

10. Please refer to the learning objectives you developed in the predisposing activity. Were your objectives met?

11. Are there any learning areas you need to follow up?

Appendix 1. Involuntary treatment

The objective of involuntary treatment is to provide for the care, treatment and protection of mentally ill people who do not, or cannot, consent to that care, treatment or protection.

Legislation (including the criteria for involuntary treatment of patients and the procedures for involuntary admission) differs from state to state and territory.

Jurisdiction	Statute
ACT	<i>Mental Health (Treatment and Care) Act 1994</i>
New South Wales	<i>Mental Health Act 2007</i>
Northern Territory	<i>Mental Health and Related Services Act 1998</i>
Queensland	<i>Mental Health Act 2000</i>
South Australia	<i>Mental Health Act 2009</i>
Tasmania	<i>Mental Health Act 2013</i>
Victoria	<i>Mental Health Act 2014</i>
Western Australia	<i>Mental Health Act 2013</i>

Visit www.comlaw.gov.au for access to the current mental health legislation for each jurisdiction.

Police and/or ambulance officers in attendance at a scene requiring the care or treatment of a mentally ill person will generally be able to advise a practitioner of the appropriate action as the situation requires.

Appendix 2. Example responses to drug-seeking behaviour

Alprazolam and temazepam have been used frequently in scenarios below. These may be substituted for other benzodiazepines. Some responses are specific for alprazolam and for temazepam capsules as both of these have undergone changes to Pharmaceutical Benefits Scheme (PBS) listing and Therapeutic Goods Administration (TGA) scheduling. The following table provides some options for responding to patient requests and explains the rationale for these. Note that all responses are examples only. A full table of potential responses is in the RACGP *Guide to prescribing drugs of dependence in general practice, part B: Benzodiazepines* (2015); see Resource A: 'Examples of responses to patient requests for benzodiazepines'.

Patient requests	Doctor 'scripted' responses	Comments
I need something to help me to sleep	Sometimes poor sleep indicates more serious underlying problems. Can you tell me more about your sleep issues? or What have you tried to help you sleep? or Sleeping tablets have been used in the past to help people with sleeping problems; however, we now know that they can have side effects and can be risky so we don't always prescribe them	<ul style="list-style-type: none"> You need to make a detailed assessment and diagnose the condition rather than treating a symptom Don't assume that if someone asks you to assist them with sleep that they are looking for sleeping tablets Offer a hierarchy of alternatives, including sleep hygiene and Cognitive behavioural therapy (CBT) Give written information
I want/ need a prescription for alprazolam (or other)	We don't prescribe these medications. Let's talk about how I can help you with your sleep problem without drugs or The rules around these medications have changed due to the range of harms they were causing or I'm sorry, it's my/our practice policy not to prescribe alprazolam or I don't prescribe these medications. But I'd like to know more about why you are on these medications, and the best way to manage this. Can we talk about how you came to be on these tablets? or I am concerned about that, sometimes a request of this nature is a sign that someone has become dependent on the medication. Can we talk about how much you are using?	<ul style="list-style-type: none"> Provide sleep hygiene leaflet and CBT information Alprazolam has been rescheduled as a Schedule 8 drug

Patient requests	Doctor 'scripted' responses	Comments
<p>But Dr X prescribes them (Dr X being someone in your practice or in one nearby)</p>	<p>That's Dr X's decision, but all the other doctors in this practice don't prescribe them or That's Dr X's decision, but the doctors in this practice insist on continual monitoring of patients they prescribe to or That's Dr X's decision, but all the other doctors in this practice have very strict criteria for which they prescribe or If that doctor prescribed it for you before, it may be best for you to go back to him/her. They know your history better than I do, and it's best to continue with the one doctor</p>	<ul style="list-style-type: none"> • Discuss this issue with Dr X. Develop a practice policy (or local area policy) if your ability to handle requests for drugs is compromised • Dr X can contact the clinical director of the alcohol and drug services for advice about appropriate prescribing of benzodiazepine medications • Ask the patient why they have not returned to the doctor who previously prescribed medication. Stress the advantages of continuity of care
<p>No, I've tried all this. The only thing that works for me is a sleeping pill. I want medication</p>	<p>Have you used medication before? Who prescribed it to you? or I am concerned about that, as sometimes a request like this can be a sign that a patient has become dependent on the medication. Can we talk about how much you are taking? or Sleeping pills are not the first choice in treating insomnia. They come with risks and limitations or Sleeping medicines only provide a short-term benefit. If you're having trouble sleeping, it may be because you've become dependent on them. Using non-drug methods has been shown to have a better long-term benefit or It's my/our firm policy not to prescribe sleeping tablets or I am concerned that providing ongoing medication is not good for your overall health. Can we trial a graduated withdrawal program, or can I refer you to a specialist? or Your sleep problems can be a result of your drug use. Giving tablets is just treating a symptom. I'd like to get to the cause and help you with your drug problem or Thank you for coming to see me ... [or] It was nice to meet you ... I am unable to prescribe the medications that you request today because I don't believe that is in your best interest and that's not the way we now practice medicine. I have mentioned alternative methods of exploring and treating your problem. Please give my advice some further thought and if you decide you would like to avail yourself of the treatment that I am able to offer you, I look forward to seeing you again. In that case, please call for another appointment</p>	<ul style="list-style-type: none"> • A patient asking for medication (especially specific medication) is a classic red flag that the patient is drug seeking • Ask the patient why they have not returned to the doctor who previously prescribed medication. Stress the advantages of continuity of care • Ask the patient about what sleep hygiene practices they have tried and gauge their knowledge. Provide further information about sleep hygiene as needed • Educate the patient about the problems associated with sleeping tablets – including abnormal sleep, often with early awakening – as well as the risks • Play a broken record on this advice. Remember, patients may no longer derive any relief from the medication, but they feel very much worse when they stop it • If the patient does not accept your advice and continues to pressure you, one option is to stand up from your chair while maintaining eye contact with the patient, walk to and open the door of your consulting room and say something like 'Thank you for coming to see me ...' or 'It was nice to meet you ... I am unable to prescribe the medications that you request today because I don't believe that is in your best interest ... if you decide ...'.

Appendix 3. Drugs and poisons units

Each state and territory has a range of requirements and service options in relation to drug-seeking behaviour. For more information about what is required of medical practitioners in each state/territory, visit your state/territory drugs and poisons unit website.

For example, in Victoria medical practitioners may phone the Drugs and Poisons Regulation Group (DPRG) on 1300 364 545 (10.00 am – 4.00 pm, Monday to Friday) to discuss concerns or to seek information about specific patients.

Medical practitioners who contact DPRG may be able to establish:

- whether any other medical practitioner holds a permit to treat a patient with Schedule 8 drugs, including patients receiving methadone or buprenorphine to treat opioid-dependence
- aliases that have reportedly been used by drug-seeking patients
- whether DPRG has received notifications that other medical practitioners had reason to believe a patient was a drug-dependent person and whether that practitioner had indicated an intention to treat the patient
- whether reports of forged or fraudulent prescriptions, or of obtaining drugs of dependence by false representation, had been received in relation to the patient.⁶⁵

Information available from DPRG differs from that of the PSIS described in Appendix 4, because it is not limited to medications that are PBS items or to a three-month period. However, in most cases, DPRG does not have details of prescriptions that have been recently dispensed for a patient. Therefore, it may be necessary to also contact the PSIS to ascertain a patient's full history.

Appendix 4. Prescription shopping

Prescription shopping is when a patient unknowingly or deliberately seeks/obtains more medicine than they need by visiting many doctors without telling them about their other consultations.

Patients may seek more medicines than they need because they may be:

- stockpiling them for later use
- satisfying a drug dependency
- selling, exchanging or giving medicines to relatives
- illegally exporting them overseas.⁵⁰

GPs should be aware that the drugs most commonly subject to misuse or trafficking include larger strengths of oxycodone, morphine, injectable opioids, anabolic steroids, benzodiazepines (especially alprazolam) and preparations containing pseudoephedrine.⁸⁵

The Prescription Shopping Information Service (PSIS)

If you suspect a patient of requesting medicine in excess of medical need, you can call Medicare Australia's PSIS (1800 631 181).

Legislative provisions are in place to protect doctors who enquire about/report potential 'prescription shoppers' under the Prescription Shopping Program (PSP).

Once a doctor is registered with the PSP, they can call the PSIS 24 hours a day, seven days a week, to find out if their patient has been identified as a prescription shopper under the program. It is preferable, but not essential, to obtain patient consent before you contact the service.

If the patient has met the PSP criteria, and been identified as a prescription shopper, the doctor can then request information about the type and amount of PBS medicines that the patient has received from different prescribers over a recent three-month period.

The criteria that must be met for a patient to be identified as a prescription shopper are as follows.

Over a recent three-month period, the patient must have been:

- prescribed PBS medicine by six or more different prescribers (excluding specialists), or
- prescribed/dispensed 25 or more 'target items', or
- prescribed/dispensed 50 or more PBS medicines.⁵⁸

'Target items' are analgesics, anti-epileptics, anti-Parkinson medicine, psycholeptics, psychoanaleptics, other central nervous system drugs, serum lipid-reducing agents, drugs for peptic ulcers and gastro-oesophageal reflux, antibacterials (for systemic use), anti-inflammatory/rheumatic products, insulin (and analogues) and anti-hypertensives.

According to the *Health Insurance Act 1973*, interpretation, a 'specialist':

in relation to a particular specialty, means a medical practitioner in relation to whom there is in force a determination under section 3DB or 3E that the medical practitioner is recognised for the purposes of this Act as a specialist in that specialty, or a medical practitioner who is taken to be so recognised under section 3D.

The patient information provided to registered doctors does not include:

- PBS medicines where the full cost is less than the patient contribution
- emergency drug (doctor's bag) supplies
- PBS medicine supplied by a pharmacist in an emergency
- medicine subsidised under the Repatriation Pharmaceutical Benefit Scheme (RPBS)
- non-PBS medicine, such as private prescriptions and medications dispensed by public hospitals
- PBS Schedule section 100 (of the *National Health Act 1953*) medicines (including programs for highly specialised drugs, botulinum toxin, human growth hormone, IVF/GIFT, opiate dependence treatment, special authority).⁶³

In order for this program to be effective, all GPs must be active in using it. More information on the PSP can be accessed at www.medicareaustralia.gov.au/provider/pbs/prescription-shopping, or by calling Medicare Australia on 1800 631 181.

Appendix 5. Proforma warning letter

[Insert practice address]

[Date]

Dear Mr/Ms

Staff at [insert practice name] have recently reported an incident [insert date or approximate date when the incident occurred] where you [insert a phrase that objectively describes the patient's violent behaviour] and that they were threatened by your behaviour.

The practice has a duty of care to ensure that the safety of patients and staff in the practice is maintained. Therefore we cannot tolerate your threatening behaviour.

We are prepared to continue with your treatment at this practice provided that you are willing to significantly modify your behaviour. We propose to develop a mutually acceptable behaviour agreement with you. This agreement will outline the conditions and behaviours we expect at the practice, and the consequences of breaching these conditions.

If you wish to enter into a behaviour agreement, please ring the practice to discuss this letter. An alternative to an agreement about your behaviour would be for you to seek care with another GP.

We will transfer a copy of your health record to your new GP on receipt of their contact details in writing.

Yours sincerely

Practice Manager

Appendix 6. Proforma acceptable behaviour agreement

Acceptable behaviour agreement

I, [individual], agree to enter into an agreement with [practice name] ('the practice') based on the following conditions.

As a condition of the practice agreeing to continue my treatment, I promise that I will not whilst I am in the clinic:

- swear at staff or in the presence of other patients
- shout or make offensive remarks
- make verbal or physical threats
- attend when intoxicated with alcohol and/or drugs
- damage or steal property
- act in a manner that is likely to cause harassment, alarm, or distress to others in the general practice
- [other].

If I breach this agreement I understand that:

- I may be asked to leave the practice
- police attendance may be requested by practice staff, and
- my future attendance at this practice may be discontinued and I may have to seek health care elsewhere.

DECLARATION

I confirm that I understand and agree to the conditions of this undertaking.

I also acknowledge that the consequences of breaching the conditions of the acceptable behaviour agreement have been explained to me.

SIGNED

DATE

WITNESS

DATE

(GP, nurse or senior staff member)

Appendix 7. Obtaining an intervention order

Jurisdiction	Sources of further information about the process
<p>Australian Capital Territory</p>	<p>In the Australian Capital Territory (ACT), the complainant (in our case, either GP or staff member) can apply for a Personal Protection Order (PPO) under the <i>Domestic Violence and Protection Orders Act 2008</i>. This is done through a local Magistrate's Court. The court does not currently charge any fees for making an application for a protection order.</p> <p>Applicants typically complete an application form, affidavit, and other confidential forms that are used by the court, and provided to the Australian Federal Police, for the purpose of serving the respondent with summons documents. If required, the magistrate can grant interim orders until a hearing is held and a final order is granted.</p> <p>Further information about the application process, forms and fees can be found at:</p> <ul style="list-style-type: none"> • www.courts.act.gov.au/magistrates/page/view/3259/title/information-for-those-wanting-to • www.courts.act.gov.au/magistrates/page/view/1841
<p>New South Wales</p>	<p>In New South Wales (NSW), the complainant (in our case, either GP or staff member) can apply for an Apprehended Personal Violence Order (APVO) through the local courts under the <i>Crimes (Domestic and Personal Violence) Act 2007</i>.</p> <p>An application for an APVO can be made in two ways:</p> <ul style="list-style-type: none"> • by the police on your behalf (called a 'police application') • by you personally at your local court (called a 'private application'). <p>A police application involves the applicant contacting the police and providing a signed statement of events. The police will then 'serve' (hand deliver) the APVO application to the respondent and send a Statement of Service to the local court. Both parties are then required to go to court at the designated time and date. When the police apply for an APVO on your behalf, you are represented at court by a police prosecutor.</p> <p>If the threat of violence is not imminent, the complainant has the option of submitting a private application. In this case, the applicant is required to contact the court directly themselves, and fill out and sign the prescribed forms. The police or another person nominated by the court then serve the application to the respondent. Both parties are then required to go to court on the nominated date and time. The applicant will need to represent themselves or get a lawyer.</p> <p>If a threat of violence is imminent (eg a threatening patient is in the practice or consulting room), contact the police in the first instance. The police can remove the offending party and then, if there are grounds, apply for a provisional APVO protecting the applicant until the case is heard in court.</p> <p>Further information about the application process, forms and fees can be found at:</p> <ul style="list-style-type: none"> • www.localcourt.justice.nsw.gov.au/Pages/cases/avo_procedures.aspx • www.lawassist.lawaccess.nsw.gov.au/lawassist/lawassist_avo.html • www.legalaid.nsw.gov.au
<p>Northern Territory</p>	<p>In the Northern Territory (NT), the complainant (in our case, either GP or staff member) can, under the <i>Justices Act 1982</i>, apply for a Personal Violence Restraining Order (PVRO) through the Magistrates Court.</p> <p>This application involves completing an application form and an affidavit. These are filed at the nearest Court of Summary Jurisdiction registry. The application will be given a court date and then the court bailiff or the police will try to serve the defendant with those documents.</p> <p>Further information about the application process, forms and fees can be found at www.nt.gov.au/justice/ntmc/forms_fees.shtml</p> <p>Also see the NT Magistrates Court Pamphlet 6: 'Personal Violence Restraining Orders Justices Act section 82', at www.nt.gov.au/justice/ntmc/documents/Pamphlet6_001.pdf</p>

Jurisdiction	Sources of further information about the process
Queensland	<p>In Queensland, the complainant (in our case, either GP or staff member) can apply for a Peace and Good Behaviour Order (PGBO) under the <i>Peace and Good Behaviour Act 1982</i>.</p> <p>The process involves initially completing a Complaint and Summons form obtained from your local Magistrates Court. This must be sworn and signed before a Justice of the Peace (JP).</p> <p>If (upon review) the JP is satisfied that there are reasonable grounds for the applicant to be in fear of the person they are complaining about, and that the defendant has a case to answer in court, the JP will issue a summons directing the defendant to appear at a certain time and date before a Magistrates Court. It is then the applicant's responsibility to:</p> <ul style="list-style-type: none"> • file the original complaint and summons with the Magistrates Court registry closest to where the defendant lives or where the incident or threat took place • pay the relevant filing fee when lodging the complaint • organise for the summons to be hand delivered/served on the defendant. <p>While a GP (if the applicant) can serve a summons, it's recommended that a person not directly involved serve the summons. The police, a court bailiff or a private 'process server' can perform this role for a fee.</p> <p>Once the summons is served, both parties are required to attend and present their version of events and supporting evidence in the form of a sworn affidavit – with or without legal representation. At the court hearing, the magistrate can issue a PGBO protecting the applicant generally for 12 months. Alternatively, the magistrate may request a mediation process.</p> <p>Further information about the application process, forms and fees can be found at:</p> <ul style="list-style-type: none"> • www.courts.qld.gov.au/forms • www.courts.qld.gov.au/about/fees <p>Also see the Queensland Courts fact sheet 'Applying for protection under the Peace and Good Behaviour Act' available at www.courts.qld.gov.au/__data/assets/pdf_file/0009/84555/m-fs-peace-and-good-behaviour.pdf</p>
South Australia	<p>In South Australia (SA), the complainant (in our case, either GP or staff member) can apply for an Intervention Order under the <i>Intervention Orders (Prevention of Abuse) Act 2009</i>.</p> <p>An Intervention Order can be made if it is reasonable to suspect that the defendant will, without intervention, commit an act of abuse against a person and the issuing of the order is appropriate in the circumstances.</p> <p>The Intervention Order legislation is anticipatory in nature, aimed at reducing risk of abuse and can be issued if there is sufficient reason to suspect harm will occur.</p> <p>Unlike the previous restraining order legislation, there is no requirement to show evidence that actual harm has already occurred or actual threats have already been made. However, to show the defendant may commit an act of abuse, the protected person will need to indicate what behaviour of the defendant gives rise to this suspicion.</p> <p>An application for an Intervention Order can be made by either:</p> <ul style="list-style-type: none"> • the police on your behalf • you personally at your local Magistrates Court. <p>If you need immediate protection, call the police. The police have the power to issue an interim Intervention Order if the defendant is present or in custody.</p> <p>The interim Intervention Order will give you protection as soon as the defendant is notified. It will also allow you to have immediate protection from abuse without the need to go to court first. An interim Intervention Order issued by the police requires the defendant to appear in court (usually within eight days) for the court to decide if the order should be confirmed or revoked.</p> <p>If the police have not issued an interim Intervention Order then you, your representative or the police may apply to the Magistrates Court for an Intervention Order using the relevant application forms.</p> <p>There will then be a preliminary hearing at which the magistrate will decide whether there is enough evidence to issue an interim Intervention Order.</p> <p>The court must be convinced it is reasonable to suspect that the defendant will commit an act of abuse. If so, this will be served upon the defendant by the police. The defendant will then be required to appear in court within eight days (or within two days of the court next sitting at that place).</p> <p>Further information about the application process, forms and fees can be found at:</p> <ul style="list-style-type: none"> • Courts Administration Authority of South Australia: www.courts.sa.gov.au • Legal Services Commission of South Australia: www.lsc.sa.gov.au <p>Also see the Legal Services Commission of South Australia Law Handbook, available at www.lawhandbook.sa.gov.au/ch21s07s02s07.php</p>

Jurisdiction	Sources of further information about the process
Tasmania	<p>In Tasmania, the complainant (in our case, either GP or staff member) can apply for a Restraining Order under the <i>Justices Act 1959</i>. An application for a Restraining Order can be made by either:</p> <ul style="list-style-type: none"> • the police on your behalf • you personally at your local Magistrates Court. <p>When an application is urgent, a hearing usually occurs on the same day the application is lodged with the court. The purpose of the urgent hearing is to consider making interim orders and set a time for a formal hearing. The application for the formal hearing is normally given to (served on) the respondent by a ‘process server’ (for a fee) or police officer. The application includes a ‘Notice of Hearing’ giving the date and time of the formal hearing at which the respondent should attend.</p> <p>The purpose of a formal hearing is give the respondent the opportunity to say whether they consent to the orders. The matter may have to go to a final hearing if the respondent contests the application.</p> <p>A Restraining Order can be made against a person who has:</p> <ul style="list-style-type: none"> • caused personal injury or damage to property and, unless restrained, is likely to do this again • threatened to cause personal injury or damage to property and, unless restrained, is likely to carry out that threat • behaved in a provocative or offensive manner, likely to lead to a breach of the peace, and, unless restrained, is likely to do this again • stalked the applicant, or has stalked someone else, causing the applicant apprehension or fear. <p>The magistrate must consider the protection and welfare of the applicant to be of paramount importance.</p> <p>The types of orders that can be made include:</p> <ul style="list-style-type: none"> • an order directing the person to vacate premises, restraining that person from entering premises, or limiting that person’s access to premises, regardless of whether or not that person has a legal or equitable interest in the premises • an order prohibiting or restricting the possession by the person against whom the order is made of all or any firearms, or directing the forfeiture or disposal of any firearms in their possession • an order prohibiting the person against whom the order is made from stalking the applicant. <p>Further information about the application process, forms and fees can be found at www.magistratescourt.tas.gov.au/going_to_court/restraint_orders</p>
Victoria	<p>In Victoria, the complainant (in our case, either GP or staff member) can apply for a Personal Safety Intervention Order (PSIO) under the <i>Personal Safety Intervention Orders Act 2010</i>.</p> <p>Obtaining a PSIO in Victoria takes three steps:</p> <ul style="list-style-type: none"> • The person seeking the PSIO contacts the closest Magistrates Court, speaks with a court registrar and fills in an application form. • The police notify the defendant about the complaint. • The magistrate has a court hearing and decides whether to make the order. <p>Further information about the application process, forms and fees can be found at:</p> <ul style="list-style-type: none"> • www.magistratescourt.vic.gov.au (search ‘intervention order’) • www.magistratescourt.vic.gov.au/jurisdictions/intervention-orders/personal-safety-intervention-orders <p>Victoria Legal Aid also offers detailed information on intervention orders, including various booklets and fact sheets. Available at www.legalaid.vic.gov.au/find-legal-answers/personal-safety-intervention-orders</p>

Jurisdiction	Sources of further information about the process
Western Australia	<p>In Western Australia (WA), the complainant (in our case, either GP or staff member) can apply for one of two types of restraining orders:</p> <ul style="list-style-type: none">• Misconduct Restraining Order – made when a person behaves in an intimidating or offensive manner that may lead to a breach of the peace or damaged property.• Violence Restraining Order – made when an act of abuse has been committed, or it is feared that it will be committed. <p>An application for either type of order can be made by a police officer on behalf of a person/ group or by the person seeking protection. Applications for either type of order can be made at a Magistrates Court.</p> <p>In crisis situations, police can issue a 24- or 72-hour police order. Local police can also issue a 24-hour 'temporary' restraining order in extraordinary cases while the main application is being processed.</p> <p>The application is then lodged through the courts and is usually approved within 48 hours. The police then serve the restraining order. Unless doctor–patient confidentiality issues arise, here is no need to obtain a lawyer if the application is straightforward.</p> <p>Further information about the application process, forms and fees can be found at:</p> <ul style="list-style-type: none">• www.magistratescourt.wa.gov.au/• www.justice.wa.gov.au• www.police.wa.gov.au

Appendix 8. Proforma letter to discontinue care

[Insert practice address]

[Date]

Dear Mr/Ms

Staff at [insert practice name] have recently reported an incident [insert date or approximate date]
Staff at [insert practice name] have recently reported an incident where you [insert a phrase
that objectively describes the patient's violent behaviour] and that they were threatened by
your behaviour.

The safety of patients and staff in this practice is very important to us. Therefore, we cannot
tolerate your threatening behaviour of [insert date].

As a result, we are discontinuing your care at [insert practice name].

This means that you are unable to attend this practice for ongoing medical care. Please do
not contact the practice or come to the practice for an appointment. Please find another
clinic at which to receive your healthcare.

We will transfer a copy of your health record to your new clinic when we receive a written
request with the new clinic's contact details.

Yours sincerely

Practice Manager

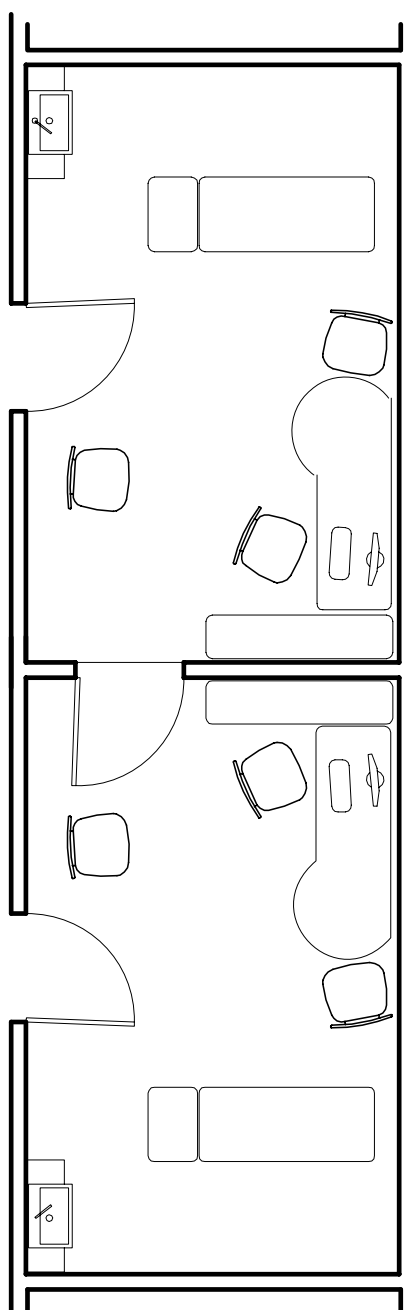
Appendix 9. Layout of the consulting room

Figure 1 demonstrates two examples of design and layout of a consulting room. The design reveals two exit points in each consulting room, with the clinician seated closest to an exit point.

Extra seating space allows patients to bring family and friends into the consulting room.

The figure also demonstrates how to design consulting rooms with examination beds positioned away from the wall, allowing 360-degree access when examining patients.

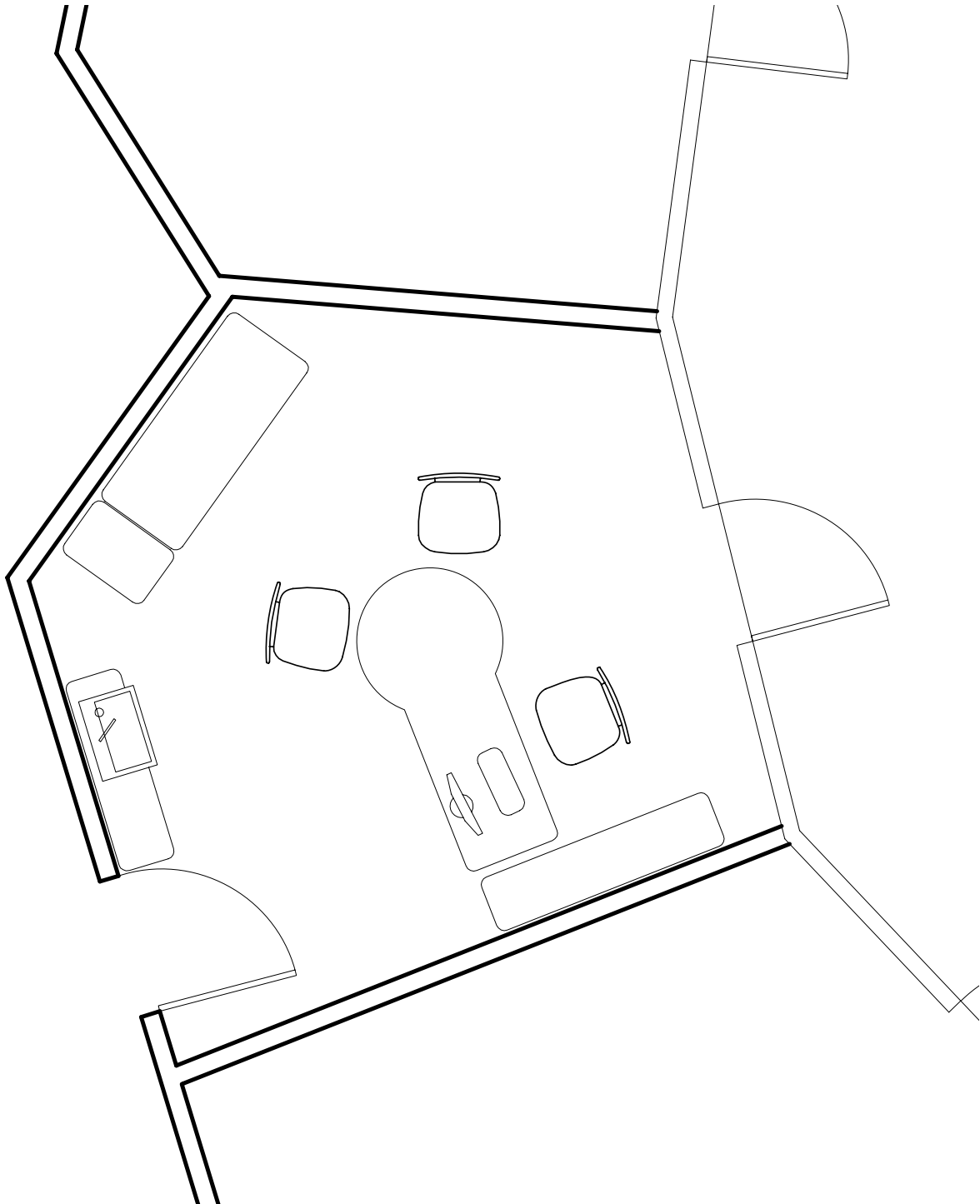
Figure 1. The consulting room (a)



Source: The Royal Australian College of General Practitioners. *Rebirth of a clinic: A design workbook for architecture in general practice and primary care.* Watts I, Editor. Melbourne: RACGP and RMIT University, 2008. © Samantha Neumann. The resource is available to purchase in hard copy from RACGP publications at www.racgp.org.au/publications/orders

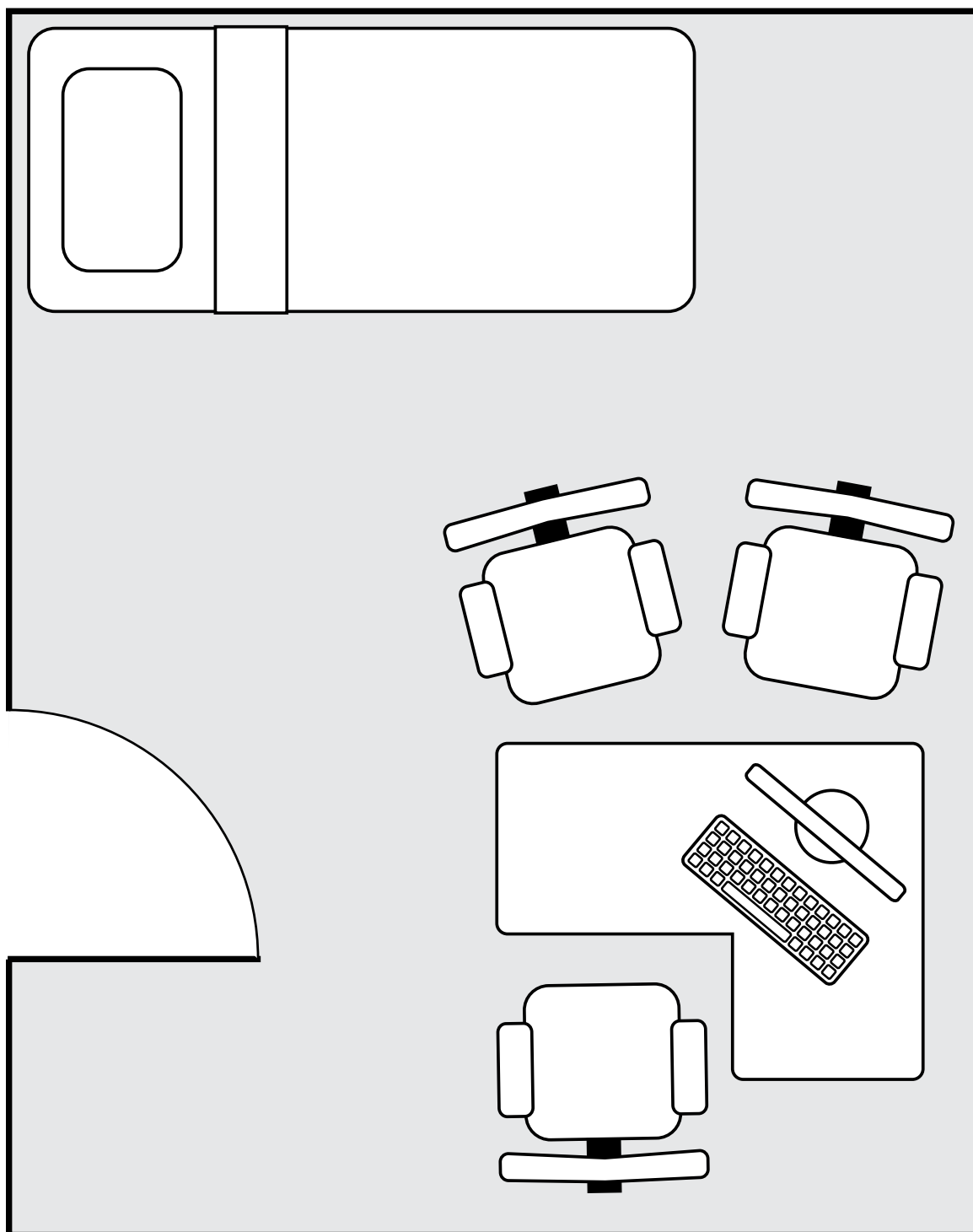
Figure 2 and Figure 3 illustrate that, however desirable, it is sometimes not practical to incorporate a stand-alone examination couch in the consulting room. Both designs nevertheless demonstrate an uncluttered consulting environment.

Figure 2. The consulting room (b)



Source: The Royal Australian College of General Practitioners. *Rebirth of a clinic: A design workbook for architecture in general practice and primary care*. Watts I, Editor. Melbourne: RACGP and RMIT University, 2008. © Samantha Neumann. The resource is available to purchase in hard copy from RACGP publications at www.racgp.org.au/publications/orders

Figure 3. The consulting room (c)



Source: The Royal Australian College of General Practitioners. *Rebirth of a clinic: A design workbook for architecture in general practice and primary care*. Watts I, Editor. Melbourne: RACGP and RMIT University, 2008. © Samantha Neumann. The resource is available to purchase in hard copy from RACGP publications at www.racgp.org.au/publications/orders

References

1. Australian Bureau of Statistics. Personal safety survey Australia. Canberra: ABS, 2012.
2. Di Martino V. Workplace violence in the health sector: Country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study. Synthesis report. Geneva: International Labour Office, International Council of Nurses, World Health Organization and Public Services International. Joint Programme on Workplace Violence in the Health Sector, 2002.
3. John Doyle, Victorian Auditor-General. Occupational violence against healthcare workers. PP No 30, Session 2014–15. Melbourne: Victorian Government Printer, 2015. Available at www.audit.vic.gov.au/publications/20150506-Occ-Violence/20150506-Occ-Violence.html [Accessed June 2015].
4. Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers. Arlington Heights, IL: OSHA, 2015. Available at www.osha.gov/Publications/osha3148.pdf [Accessed June 2015].
5. Mayhew C, editor. Preventing violence against health workers. Paper presented at WorkSafe Victoria Seminar, June 2003.
6. Mayhew C, Chappell D. The occupational violence experiences of 400 Australian health workers: An exploratory study. *J Occup Health Safety Aust NZ* 2003;19(6):3–43.
7. Magin P, Adams J, Sibbritt D, Joy E, Ireland M. Experiences of occupational violence in Australian urban general practice: A cross-sectional study of GPs. *Med J Aust* 2005;183:352–56.
8. Magin P, Adams J, Joy E. Occupational violence in general practice. *Aust Fam Phys* 2007;36:955–58.
9. Forrest L, Parker R, Hegarty K, Tuschke H. Patient initiated aggression and violence in Australian general practice. *Aust Fam Phys* 2010;93(9):323–26.
10. Mayhew C. Preventing client-initiated violence – A practice handbook. Research and Public Policy Series no. 30. Canberra: Australian Institute of Criminology, 2000.
11. Koritsas S, Coles J, Boyle M, Stanley J. Prevalence and predictors of occupational violence and aggression towards GPs: A cross-sectional study. *Br J Gen Pract* 2007;57:967–70.
12. FindLaw Australia. Assault laws in Australia: Definitions and defences. Available at www.findlaw.com.au/articles/4274/assault-laws-in-australiadefinitions-and-defences.aspx [Accessed June 2015].
13. Judicial College of Victoria. Criminal charge book. 7.4.4.1.1 – Bench notes: Common law assault. Available at www.judicialcollege.vic.edu.au/eManuals/CCB/index.htm#4957.htm [Accessed June 2015].
14. Criminal Code Act 1988. Section 245 Definition of assault. Queensland consolidated acts. Available at www.austlii.edu.au/au/legis/qld/consol_act/cc189994/s245.html [Accessed June 2015].
15. FindLaw. Assault, battery and intentional torts. Available at <http://injury.findlaw.com/torts-and-personal-injuries/assault-battery-intentional-torts.html> [Accessed June 2015].
16. FindLaw. Assault and battery overview. Available at <http://criminal.findlaw.com/criminal-charges/assault-and-battery-overview.html> [Accessed June 2015].
17. Magin P, May J, McEduf P, Goode S, Adams J, Cotter G. Occupational violence in general practice: A whole of practice problem. *Aust Health Rev* 2011;35:75–80.
18. Tolhurst H, Baker L, Murray G, Bell P, Sutton A, Dean S. Rural general practitioner experience of work-related violence in Australia. *Aust J Rural Health* 2003;11:231–36.
19. Hills D, Joyce C, Humphrey's J. Prevalence and prevention of workplace aggression in Australian clinical medical practice. *Aust Health Rev* 2011;35:253–61.
20. Forrest LE, Herath PM, McRae IS, Parker RM. A national survey of general practitioners experience of patient initiated aggression in Australia. *Med J Aust* 2011;194:605–8.
21. Holmes C. Violence, zero tolerance and the subversion of professional practice. *Contemp Nurse* 2006;21:212–22.
22. Forrest L, Parker R, Ceramidis A. A national survey of general practice staff experience of patient initiated aggression 2010. Australian Primary Health Care Research Institute. ANU College of Medicine, Biology and the Environment.
23. Forrest LE, McRae IS, Parker RM. Patient initiated aggression: Prevalence and impact for general practice staff. *Aust Fam Phys* 2011;40:415–18.
24. Magin PJ, Joyce T, Adams J, Goode S, Cotter G. Receptionists' experiences of occupational violence in general practice: A qualitative study. *Br J Gen Pract* 2009;59(565):578–83.
25. Hills DJ, Joyce CM, Humphreys A. A national study of workplace aggression in Australian clinical medical practice. *Med J Aust* 2012;197:336–40.
26. Magin PJ, Adams J, Sibbritt DW, Joy E, Ireland MC. Effects of occupational violence on Australian general practitioners' provision of home visits and after-hours care: A cross-sectional study. *J Eval Clin Pract* 2008;14(2):336–42.
27. Hills DJ, Joyce CM. Workplace aggression in clinical medical practice: Associations with job satisfaction, life satisfaction and self-rated health. *Med J Aust* 2014;201:535–40.
28. Chapman R, Perry L, Styles I, Combs S. Consequences of workplace violence directed at nurses. *Br J Nurs* 2009;18(20):1256–61.
29. Mayhew C, Chappell D. Workplace violence: an overview of patterns of risk and the emotional/stress consequences on targets. *Int J Law Psychiatry* 2007;30(4–5):327–39.
30. Magin P, Adams J, Ireland M, Heaney S, Darab S. After hours care – A qualitative study of GPs' perceptions of risk of violence and effect on service provision. *Aust Fam Phys* 2005;34:91–92.
31. Lancôt N, Guay S. The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggress Violent Behav* 2014;19(5):492–501.
32. NT WorkSafe. Prevention and management of aggression in health services: A guide for workplaces. Darwin: NT WorkSafe, 2012.
33. Harvard Medical School. Mental illness and violence. Harvard Mental Health Letter, 2011. Available at www.health.harvard.edu/newsletter_article/mental-illness-and-violence [Accessed June 2015].
34. Khalifeh H, Moran P, Borschmann R, et al. Domestic and sexual violence against patients with severe mental illness. *Psychol Med* 2015;45(4):875–86.
35. Kamperman AM, Henrichs J, Bogaerts S, et al. Criminal victimisation in people with severe mental illness: A multi-site prevalence and incidence survey in the Netherlands. *PLoS ONE* 2014;9(3):e91029.
36. Álvarez MJ, Roura P, Foguet Q, Osés A, Solà J, Arrufat FX. Posttraumatic stress disorder comorbidity and clinical implications in patients with severe mental illness. *J Nerv Ment Dis* 2012;200(6):549–52.
37. Latalova K, Kamaradova D, Prasko J. Violent victimization of adult patients with severe mental illness: A systematic review. *Neuropsychiatr Dis Treat* 2014;10:1925–39.
38. Large MM, Nielssen O. Violence in first-episode psychosis: A systematic review and meta-analysis. *Schizophr Res* 2011;125(2–3):209–20.

39. Witt K, van Dorn R, Fazel S. Risk factors for violence in psychosis: Systematic review and meta-regression analysis of 110 studies. *PLoS ONE* 2013;8(2):e55942.
40. Thomas S, Mullen P, Oglloff JR. Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls. *Acta Psychiatr Scand* 2013;128(4):306–13.
41. Nourse R, Reade C, Stoltzfus J, Mittal V. Demographics, clinical characteristics, and treatment of aggressive patients admitted to the acute behavioral unit of a community general hospital: A prospective observational study. *Prim Care Companion CNS Disord* 2014;16(3):PCC.13m01589.
42. Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: Systematic review and meta-analysis. *PLoS Med* 2009;6(8):e1000120.
43. Chang WC, Chan GH, Jim OT, et al. Optimal duration of an early intervention programme for first-episode psychosis: Randomised controlled trial. *Br J Psychiatry* 2015;206(6):492–500.
44. Morgan A, McAtamney A. Key issues in alcohol related violence. Summary paper No. 4. December 2009. Australian Institute of Criminology.
45. National Drug Council on Alcoholism and Drug Dependence. Learn about alcohol: Signs and symptoms. Available at <https://ncadd.org/index.php/learn-about-alcohol/signs-and-symptoms> [Accessed June 2015].
46. National Drug Council on Alcoholism and Drug Dependence. Learn about drugs: Signs and symptoms. Available at <https://ncadd.org/learn-aboutdrugs/signs-and-symptoms> [Accessed June 2015].
47. National Health and Medical Research Council. Consensus-based clinical practice guideline for the management of volatile substances in Australia. Melbourne: NHMRC, 2011.
48. King S. Iatrogenic opioid use disorder: An issue ignored. *Psychiatr Times* 2014;8. Available at www.psychiatrictimes.com/psychopharmacology/iatrogenic-opioid-use-disorder-issue-ignored [Accessed June 2015].
49. Raeside C. The aggressive, violent or intimidating patient. The Medical Insurance Group, 2010.
50. Videbeck SL. *Psychiatric-mental health nursing*. 6th edn. Philadelphia: Lippincott Williams & Wilkins, 2013.
51. Sim MG, Wain T, Khong E. Aggressive behaviour: Prevention and management in the general practice environment. *Aust Fam Phys* 2011;40(11):866–72.
52. Breakwell G. *Coping with aggressive behaviour*. Leicester: British Psychological Service, 1997.
53. Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Working Group. *West J Emerg Med* 2012;13(1):17–25.
54. Crisis Prevention Institute. De-escalation tips. Available at www.crisisprevention.com/en-au/Resources/Knowledge-Base/De-escalation-Tips [Accessed 14 September 2015].
55. Skolnik-Acker E. Verbal de-escalation techniques for defusing or talking down an explosive situation. Portland: Portland Public Schools, 2008. Available at http://ppsfb.wednet.edu/uploads/2/5/0/7/25071730/verbal_de-escalation.pdf [Accessed 14 September 2015].
56. WorkSafe Victoria. Prevention and management of aggression in health services: A handbook for workplaces. Melbourne: WorkSafe Victoria, 2008. Available at www.worksafe.vic.gov.au/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-healthservices-a-handbook-for-workplaces [Accessed 14 September 2015].
57. Government of South Australia. Work related violence: Preventing and responding to work related violence. Adelaide: SafeWork SA, 2014.
58. Andrade J. *Handbook of violence assessment and treatment: New approaches for mental health professionals*. New York: Springer Publishing Company, 2009.
59. National Health Service Security Management Service. Procedures for placing a risk of violence marker on electronic and paper records. UK: NHS, 2010.
60. National Health Service. Unacceptable behaviour: Guidance on warning letters and other written communications. UK: NHS, 2012.
61. Lieber S, Scotty K, Volk M. Power and control: Contracts and the patient physician relationship. *Int J Clin Pract* 2011;65(12):1214–17.
62. WorkSafe Victoria. Working safely in visiting health services. A handbook for workplaces. Melbourne: WorkSafe Victoria, 2006.
63. Levy M, editor. Don't be a hero/staying safe. QA&CPD Program. Melbourne: Melbourne Medical Locum Service, 2007.
64. Department of Health, Therapeutic Goods Administration, Poisons Standard July 2015, F2015L00844. Introduction. Canberra: TGA, 2015. Available at www.comlaw.gov.au/Details/F2015L00844 [Accessed 14 September 2015].
65. The Royal Australian College of General Practitioners. Duty of care or matter of conduct: Can a doctor refuse a person in need or urgent medical attention? *Aust Fam Phys* 2013;42(10):746–48.
66. Bird S. Ending the doctor–patient relationship. *Defence Update (MDA)* 2015;Winter:11–12.
67. Medical Insurance Group. Fact sheet: Terminating the doctor–patient relationship. Adelaide: MIGA, 2009.
68. John Doyle. Occupational health and safety risk in public hospitals. Victorian Auditor-General's Report: 2013–14. Melbourne: Victorian Government Printer, 2013.
69. Magin P, Adams J, Joy E, Ireland M and Heaney S. Violence in general practice: Perceptions of cause and implications for safety. *Can Fam Physician* 2008;54:1278–84.
70. Dillon BL. Workplace violence: impact, causes, and prevention. *Work* 2012;42(1):15–20.
71. Magnavita N. Workplace violence and occupational stress in healthcare workers: A chicken-and-egg situation-results of a 6-year follow-up study. *J Nurs Scholarsh* 2014;46(5):366–76.
72. Vellani KH. Reducing violence in healthcare facilities. *J Healthc Prot Manage* 2014;30(1):21–9.
73. Gillespie G, Gates D, Miller M and Howard P. Workplace violence in healthcare settings: Risk factors and protective strategies. *Rehabil Nurs* 2010;35(5):177–84.
74. Department of Health. Preventing occupational violence: A policy framework including principles for managing weapons in Victorian health services. Melbourne: DoH, 2011.
75. Mayhew C, Chappell D. Occupational violence: Types, reporting patterns, and variations between health sectors. Sydney: School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre, University of New South Wales, 2001.
76. Gifford M, Anderson J. Barriers and motivating factors in reporting incidents of assault in mental health care. *J Am Psychiatr Nurses Assoc* 2010;16(5):288–98.
77. Maxfield D, Grenny J, Patterson K, et al. Dialogue heals: The seven crucial conversations for healthcare professionals. VitalSmarts, 2005.
78. Geason S, Wilson P. Designing out crime: Crime prevention through environmental design. Canberra: Australian Institute of Criminology, 2002.
79. International CPTED Association. Promoting CPTED locally. Available at www.cpted.net [Accessed June 2015].
80. Queensland Government. Crime prevention through environmental design: Guidelines for Queensland: essential features for safer places. Brisbane: Queensland Government, 2007.
81. NSW Police Force. Safer by design. Available at www.police.nsw.gov.au/community_issues/crime_prevention/safer_by_design [Accessed June 2015].
82. The Royal Australian College of General Practitioners. Rebirth of a clinic: A design workbook for architecture in general practice and primary care. Watts I, editor. Melbourne: RACGP, 2008.
83. WorkSafe WA. Prevention and management of aggression in health services: A handbook for workplaces. WorkSafe WA, 2009.
84. Purvis v New South Wales (Department of Education and Training) (2003) 202 ALR 133, at 161–62.
85. Victorian Department of Health. Obtaining information relating to drug-seeking patients: Information for prescribers. Melbourne: Department of Health, 2014.



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