



AMA

AUSTRALIAN MEDICAL ASSOCIATION NORTHERN TERRITORY INC.
ABN 61 628 117 024

8 April 2015

The Secretary
'Ice' Select Committee
GPO Box 3721
DARWIN NT 0801

Dear Mr Barrett

AMA (NT) would like to offer the following submission to your enquiry. Any further information in respect to the submission by AMA (NT) should be sought from Ms Fiona Thomson at fthomson@amant.com.au or 08 8981 7479.

1. Prevalence of Amphetamine Abuse

It has been estimated that the global burden of “mental, neurological and substance use disorders” is the third leading cause of Disability Adjusted Life Years (DALY's) after cardiovascular and infectious diseases (1). Amphetamine dependence was considered to contribute to 0.1% of DALY's in total and 1.0% of all DALY's in the mental, neurological and substance abuse group (1). Whiteford et al (1) note a slight increase in amphetamine related DALY' rates for both men and women from 1990 to 2010 although it should be noted that the DALY's related to amphetamine abuse are about one tenth that of alcohol (as per Table 1(1)).

DALY's /100,000	Male 1990	Male 2010	Female 1990	Female 2010
Amphetamine Use Disorders	45.4	47.3	26.9	27.6
Cannabis use Disorders	38.8	36.7	22.3	21.3
Alcohol Use Disorders	431.0	409.9	117.2	106

Table 1: Changes in the global burden of DALY's associated with selected substances (From Whiteford et al 2015) Whiteford et al in their global survey note that amphetamine abuse was higher in South East Asia and Australasia (1). Annual prevalence rates of methamphetamine abuse are estimated to be 3.2% of adults in Australia (compared to 14% prevalence in the Philippines and 0.8% prevalence in the USA for comparative populations (2)).

Apart from the effect on health generally, treatment of people affected by substance abuse is an expensive process with the estimated total cost of treatment only for all substance use disorders in Australia generally for 2012/2013 being almost \$1.3 billion dollars (3).

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Amphetamine abuse has also been increasing in Australia's Indigenous population. Wilkes et al (4) report a prevalence rate for methamphetamine within the Aboriginal and Torres Strait population of 7% in 2004 and also note that there had been a 204% increase in methamphetamine abuse within this population from 1994 to 2004 (4). These figures, although somewhat dated are obviously a major concern to the NT where a third of the population is Indigenous. More recent prevalence figures for methamphetamine abuse amongst Indigenous Australians give figures of approximately 3% prevalence for men and 2.5% for women (5) but these are likely to be an underestimate. In addition, the admission of Indigenous Australians suffering from psychosis secondary to psychoactive substance abuse to hospital inpatient units at 3.7 times the rate expected for their population size (5) is a further significant concern related to the abuse of methamphetamine by this population.

2. Pharmacology and Clinical Effects of Amphetamines

Amphetamine tablets were available without prescription in the USA until 1951 (6) and the illicit market consisted of redirected pharmaceutical stocks.(6). In 1970, amphetamine was rescheduled, leading to reduced availability. This resulted in the illegal production of amphetamines using the PCP method. Later developments resulted in two simpler methods of production in the 1980's. These were the "Nazi" method that used ephedrine or pseudoephedrine lithium with anhydrous ammonia and the "Cold" method that used ephedrine or pseudoephedrine red phosphorous and iodine crystals (6). From the 1990's, a highly purified and smoke-able form of d-methamphetamine hydrochloride (ice) was being imported into the USA from laboratories in the Far East.

Cruikshank and Dyer (2) note that the inhaled form of methamphetamine is generally much purer than other forms such as powder, thus accounting for its enhanced addictive potential (2). Smoking methamphetamine leads to a rapid absorption into plasma with cardiovascular and subjective effects (euphoria) usually occurring within 5 to 15 minutes. The half-life of the substance in plasma is approximately 10 hours.

Cruikshank and Dyer (2) report a number of side effects associated with amphetamine intoxication including raised heart rate, respiratory rate and blood pressure(2). Altered mental states are common with agitation occurring in 20% of cases, suicidal ideation in 6-12% of cases and psychosis in 7-12% of cases. Rhabdomyolysis (or muscle breakdown) and seizures may also occur as a result of amphetamine intoxication (2). The authors also describe the phenomenon of amphetamine withdrawal that can occur from abrupt cessation and which is characterised by depression, anxiety, panic and suicidal ideation. These withdrawal symptoms are at their peak two to three days after the last dose of methamphetamine.(2). The authors also note that repeated use of methamphetamine can lead to the serotonergic and dopaminergic brain chemical systems and this can result in brain damage, neuropsychological deficits (2) and destruction of brain tissue (7).

3. The Social Effects of Methamphetamine Dependence.

A US study of methamphetamine abusers reported that 34% had committed violence whilst under the influence of the substance (8). An Australian study of people attending ED with "toxicology" issues related to recent substance abuse commented that individuals affected by amphetamine intoxication were more aggressive and significantly less alert, communicative and co-operative than people presenting under the influence of other substances (9). People intoxicated with amphetamines were also more commonly brought to ED by police and it was less likely that they would come to ED with family and friends (see Table 2).

Behaviours	Methamphetamine	Other Toxicology
Alert Co-operative	21%	29%
Anxious, Co-operative	13%	16%
Agitation and Bizarre Behaviour	20%	6%
Severe Agitation and Aggression	18%	2%
Police attendance	24%	9%
Family/Friend Attendance	23%	41%

Table 2: A comparison of 449 individuals presenting with “toxicology” related issues to St Vincent’s Hospital (Sydney) ED between October 1 and December 31 2006 (9).

Otherwise, regular use of methamphetamine is associated with problematic relationship issues. The study by Summers et al indicated that 50% of their sample felt that their methamphetamine abuse had impacted negatively on their interpersonal relationships and that significant amount of reported violence (61%) had occurred within domestic relationships (8). Sutherland et al (10) report that methamphetamine abuse is associated with high levels of violent crime and property crime and that offences are often committed whilst offenders are intoxicated. People who abused methamphetamine were almost twice as likely to commit property crime and the crimes against property and people were often opportunistic.

4. Recommendations:

The AMA has developed a previous statement in respect to Methamphetamine that is attached as Appendix A. AMA NT fully supports the recommendations of this statement. In particular, AMA NT supports the involvement of the affected person’s General Practitioner as an important component of their assessment and management.

“General Practitioners are the preferred first point of contact for most drug users, the vast majority of whom are neither in contact with the police nor with specialist drug agencies. There should be a sustained investment in the training of General Practitioners on how best to engage drug users and in the application of evidence-based brief motivational interventions that have been demonstrated to lead to positive lifestyle changes and a reduction in drug related harm. General Practitioners also need to have a range of options for referral of methamphetamine users.”

In addition, AMA NT suggests the following strategies in the NT.

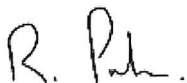
- A. Improved education in respect to the effects the substance in schools and amongst identified risk groups.
- B. Support for existing substance abuse treatment and rehabilitation programs within the NT including those conducted in prisons.
- C. Improved resources for ED Departments at RDH and ASH and NT Mental Health services to assist with the management of individuals who have mental illness and behavioural effects related to amphetamine intoxication.
- D. That NT Police, Emergency Departments and Mental Health Services be given additional resources to improve the surveillance of the incidence and prevalence of methamphetamine abuse within the NT.
- E. That there be an improved awareness of safety issues for clinicians treating individuals affected by methamphetamine as per the AMA Guideline on Personal Safety and Privacy for Doctors (Appendix B) and the Occupational Health and Safety Guidelines for General Practices developed by the Royal Australian College of General Practitioners (11).

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Yours Sincerely



Associate Professor Robert Parker
President AMA (NT)

AMA Position Statement

Methamphetamine - 2008

Methamphetamine is a stimulant drug available in a number of different forms. Powder form, traditionally known as 'speed', is usually of relatively low purity and can be snorted, injected or taken orally. Methamphetamine base, a damp oily substance, is of higher purity and is typically injected. Crystalline methamphetamine (crystal or "ice") is methamphetamine in its purest form and is usually smoked or injected. Methamphetamine use can produce an initial sense of well-being and euphoria. It heightens confidence and alertness but intoxication leads to agitation. Pseudoephedrine, available from pharmacies as a symptomatic treatment for the common cold, is the usual base for the illicit manufacture of methamphetamine.

What makes methamphetamines such a concern?

Most of the health problems related to methamphetamine use occur amongst those who have become dependent on the drug. Risk factors for dependence include smoking, injecting and frequent use, especially in those taking pure forms that produce a more intense high.

Over three quarters of dependent methamphetamine users experience serious mental health problems. The most common features are agitation or aggression, depression and anxiety, impaired concentration and motivation, and psychosis. These features sometimes, but not always, improve with abstinence.

Approximately half of dependent users have poor physical health including insomnia, poor appetite, weight loss, palpitations, nasal problems (related to snorting) and injecting site abscesses.

There is emerging evidence about the effect of methamphetamine use on cognitive functioning and memory. This has implications for prevention strategies, the design of health education programs and treatments.

Methamphetamine-induced psychosis is of particular concern to the medical profession. Out of every ten dependent users, around three will experience a psychotic episode in any one year, with paranoia and hallucinations being prominent clinical features. Such episodes may arise in people with vulnerabilities, but they also occur in people who are psychologically robust. The risk for the latter group is dose and frequency dependent. Symptoms usually last for 2-3 hours, but many users require hospitalization for their own safety or the safety of others. They require high intensity management by Emergency Department staff and mental health teams and services.

Other methamphetamine related problems include social isolation, family disruption and relationship problems, and financial problems. Injecting users are at risk of blood-borne virus infections including hepatitis B, hepatitis C and HIV. Associated high risk sexual behavior may lead to sexually transmitted infections or unplanned pregnancy. Many crimes and acts of violence are understood to be methamphetamine related.

Methamphetamines use in Australia

Methamphetamine is usually taken in a home environment with friends, often before going out to socialize. It is estimated that around 3% of Australians (aged 14 years and older) use methamphetamines at least once per year. Use is known to straddle all social groups.

Although the prevalence of methamphetamine use appears stable, the adverse health consequences of methamphetamine are increasing and impact across

society. This is why methamphetamine use is an urgent and pressing public health problem.

Methamphetamine users appear to underestimate the risks of dependence and their health consequences. While most current users take the drug infrequently, there are estimated to be approximately 73,000 dependent methamphetamine users. This compares with approximately 45,000 regular heroin users.

A range of targeted strategies, including a comprehensive public education program, are needed to reduce the harmful effects of methamphetamine use. That is, approaches used in the workplace will be different from those used in schools.

Treatment options for severe methamphetamine dependence

The Royal Australian College of Physicians noted that the absence of an effective pharmacological treatment for severe amphetamine dependence leaves an important gap in the potential treatment options. The withdrawal and abstinence syndrome can be protracted, with sleep, for example, being disrupted for a long time. It can therefore present a major challenge to health services.

Urgent research is needed to develop suitable treatment and management options for methamphetamine dependence. While increasing numbers of methamphetamine users are presenting for treatment, the links to treatment for dependent users appear tenuous, with users being less likely to come into treatment or be retained in treatment. This indicates a need to create secure environments providing physical and emotional safety for both patients and staff.

Impact on health services

A recent Western Australian study found that amphetamine related presentations accounted for 1.2% of Emergency Department presentations. Many of those who are agitated or psychotic are also heavily intoxicated with alcohol, increasing the risks of aggression towards staff and creating clinical management challenges.

Presentations related to amphetamines are typically of high acuity, result in prolonged length of stay in the Emergency Department, and consume considerable resources. A third require sedation and intensive nursing, medical and security inputs to manage them safely.

Amphetamine users frequently re-attend Emergency Departments, and it can take several days to differentiate between an amphetamine induced psychosis and exacerbations of other psychiatric conditions such as schizophrenia.

Hospital presentations for methamphetamine psychosis have increased over the past five years from 1,028 in 1999-00 to 1,510 in 2004-05. Not all need the high intensity care available by admission as an inpatient. It is possible that many patients who are agitated rather than psychotic can be managed more appropriately in a low intensity environment rather than admitting them to hospital or police custody.

The number of patients attending their General Practitioner for help with methamphetamine related health problems such as sleep, mood or eating disorders or family relationship disruption is unknown. However, evidence indicates that the General Practitioner is a preferred source of help for many methamphetamine users and that early intervention within primary care may help prevent dependency and the onset of more serious health consequences.

The AMA believes that:

1. There is clear medical evidence that methamphetamine is a harmful drug, at both the individual and community level.
2. Methamphetamine psychosis is one of the most damaging health consequences of methamphetamine use. It also presents a safety issue for health care staff.

Emergency Departments and other health care facilities must be adequately staffed to ensure personal safety at all times.

3. A renewed, comprehensive and sustained public education program on the health and social consequences of methamphetamine use is needed.
4. All pseudoephedrine-based medications should be scheduled at a minimum S3 (pharmacist only), with strict control of quantities supplied, in accordance with therapeutic standards and professional guidelines.
5. Methamphetamine should never be referred to in the media as a 'recreational', 'soft' or 'party' drug.
6. In order to reduce the health and social consequences arising from methamphetamine and other drug misuse, public policy should provide for generic programs, such as Life Skills, aimed at young people.
7. General Practitioners are the preferred first point of contact for most drug users, the vast majority of whom are neither in contact with the police nor with specialist drug agencies. There should be a sustained investment in the training of General Practitioners on how best to engage drug users and in the application of evidence-based brief motivational interventions that have been demonstrated to lead to positive lifestyle changes and a reduction in drug related harm. General Practitioners also need to have a range of options for referral of methamphetamine users.
8. There is a need for further research into the best treatments for those with severe methamphetamine dependence.
9. Emergency Department staffing should include a specialist drugs liaison officer, available to engage and support those presenting with methamphetamine and other drug related problems.
10. Further research is needed on the needs of patients with methamphetamine related problems presenting to Emergency Departments and their accommodation requirements. Low intensity supervised hostel-type accommodation may be most suited to the needs of medically stable but agitated users who are not psychotic, rather than admitting them to hospital or police custody.

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PERSONAL SAFETY AND PRIVACY FOR DOCTORS

2005

Preamble

The AMA recognises that violence against doctors is a growing concern. This Position Statement is provided in an effort to reduce the vulnerability of medical practitioners to physical harm in all locations or settings in which they practise or may be exposed to personal danger arising from their professional work as doctors. It is recognised that there will be wide variation in the level of risk, the practicality of protective measures for prevention of threats to personal safety and the availability of emergency help when such threats do arise.

The statement is framed within a risk management approach, focussing on risk identification, risk assessment, risk control and evaluation of the effectiveness of risk management strategies. It is intended to guide the violence management efforts of hospitals, practice managers and individual doctors – these parties should also keep up to date with current literature on the subject.

Scope

Standard workplaces for doctors include public and private hospitals, other health and aged care facilities and private practices. Many doctors work shifts and many provide after hours services and home visits to patients in the community. Some doctors attend accident scenes and other locations requiring travel by vehicle, boat or aircraft. There is obviously a wide range of workplaces.

Some of these workplaces, such as major hospitals, are able to provide formal protective measures in terms of both prevention of and responses to violence against doctors and other staff. Others, such as small hospitals and private practices, cannot provide the same sorts of formal protective measures, but they should apply the principles set out in this statement in regard to the personal safety and security of doctors. In these smaller workplaces the risk of violence may be lower, but the impact of it is likely to be higher when it occurs because of the lack of immediate response and assistance from security staff or police. This also applies where doctors are working on their own, particularly outside static workplaces, for example on home visits or emergency callouts.

In addition, there are times when the process of consultation and treatment of medical conditions can involve the transmission of deeply sensitive information regarding both the patient and other individuals. Such information generally remains private between the parties, but in some circumstances statutory obligations will require the doctor to convey appropriate information to the relevant authority. This can include information regarding infectious diseases, fitness to drive motor vehicles, etc. The repercussions of these obligatory disclosures can be profound for the patient and, where there is emotional or psychological instability, for others. Doctors involved in these work situations may find themselves faced with threats to their personal safety even while at home or otherwise going about their private business. Thus occupational safety strategies for doctors may need to address risks outside the workplace.

Managing Risk

Every State and Territory has occupational health and safety (OH&S) legislation that places on employers a general duty of care to provide and maintain a safe and healthy workplace. The legislation also assigns to each employee a duty to take reasonable care for their own health and safety, as well as for the health and safety of others who may be affected by that employee's acts or omissions at the workplace.

Violence risk management needs to take into consideration the work environment as a whole. To be successful it requires the commitment of management through sufficient investment of time, money and personnel. This includes commitment to regular audits of the organisation's vulnerability to violence to inform risk management planning.

Consultation with staff is essential for violence risk management planning to be effective. A risk management methodology can be used in conjunction with the detailed knowledge of staff in the local work environment to develop tailored solutions to violence problems. It may be appropriate to assemble a working group of staff to develop a violence risk management plan.

1. Risk Identification

- 1.1 The identification of risks in relation to violence should take into account information from workplace inspections and security assessments, incident and accident reports/investigations, Workers Compensation records, complaints, and other information obtained from staff and users of healthcare facilities.
- 1.2 A system should be in place for reporting violent incidents and staff should be encouraged to report all violent or aggressive incidents that have endangered, or have had the potential to endanger, a staff member's safety.

2. Risk Assessment

- 2.1 Assessments of identified risks should be undertaken to arrive at ratings of both the likelihood of each risk occurring and its impact. These ratings should be used to ascertain the level of each risk so that the relative priority of actions to deal with these risks can be determined.

3. Risk Control

The resourcing and timing of steps to control (eliminate or minimise) risks should reflect the level of each risk as identified through risk assessment. Risk control should include, but not be limited to, the following:

Policy on Violence

- 3.1 The organisation should develop a zero tolerance policy regarding the management of violence and ensure that staff understand it.

Complaints Mechanism

- 3.2 A complaints mechanism should be available for staff and users of healthcare facilities in order to encourage problems to be addressed in a non-violent manner.

Physical Environment

- 3.3 Surroundings should be made as comfortable as possible for users of health care facilities to help lower distress amongst those with health concerns.
- 3.4 There should be sufficient lighting inside and in the immediate vicinity of the hospital to provide a safe and secure working environment.
- 3.5 External doors should be locked at night with only the main entrances, which should be under staff surveillance, left open for public access.
- 3.6 Staff should have access to secure lockers in which valuables can be stored while working.
- 3.7 Sufficient car parking spaces should be available to provide for all doctors rostered on at any particular time or likely to be called in, including specific doctors' parking for on call/after hours work. These spaces should be within close proximity of the area of the building in which the doctor is working, sufficiently well lit to provide secure access at night, and reserved for staff use only.
- 3.8 Staff only areas (including staff office areas, staff common rooms, and other restricted areas) should be accessible only via restrictive access devices such as card keys with photo identification.
- 3.9 Video surveillance in appropriate areas should be considered and, where implemented, signs should be prominently posted advising of its presence to maximise its deterrence value.

Personal Protection

- 3.10 Duress alarms should be provided where practicable for doctors exposed to higher-risk situations, including doctors working in mental health treatment areas, emergency departments and in settings where there is little organisational backup or delays in getting emergency help, such as after hours surgeries. Duress alarms should also be provided in Resident Medical Officer quarters and in hospital corridors assessed as dangerous.
- 3.11 Where doctors are required to walk significant distances to their cars or walk to their cars at night, an escort should be available upon request to facilitate a safe passage.

Protecting Personal Privacy

- 3.12 Employers must ensure that the personal privacy of doctors is protected, particularly sensitive details such as private address and contact numbers. This is particularly important in situations where the nature of doctors' work places them at risk of harassment and violence from unstable or maladjusted patients.
- 3.13 The AMA's position in relation to the personal privacy of doctors is as follows:
1. It is a fundamental right for the occupational health and safety of medical practitioners providing services to patients, in any setting, for the personal private details of doctors, including residential address, to remain strictly confidential.
 2. OH&S principles, as they relate to medical practitioners, require strict observance of the doctor's need for personal privacy. Further, under no circumstances should a doctor's contact address provided to an employer or Medical Board be made publicly available or be included in publicly accessible databases by medical practitioner registration boards or similar authorities unless the doctor has expressly consented to have the information made available.
 3. Any disclosure of a doctor's private personal information, including private residential address, by an individual, agency or authority, from either the public or private sector, is a clear breach of OH&S principles as they relate to medical practitioners.

Education and Training

- 3.14 Doctors, other healthcare staff, patients and their visitors should be provided with information regarding behaviour expected of them in a health care setting.
- 3.15 Staff should be provided with a copy of the organisation's policy on violence and understand what action they should take to address concerns that may arise.
- 3.16 Staff should be given appropriate training to assist with the management of violence. Preventative approaches should be covered as part of such training, including the skill of projecting a pleasant manner to help prevent feelings of resentment and alienation on the part of users.
- 3.17 Staff should be provided with information regarding the identification and assessment of risks in relation to violence in their work environment, as well as control measures to address the risks.

Home Visits

- 3.18 Guidelines should be in place to protect doctors undertaking home visits. These may include, for example, providing security escorts upon request, keeping timetables recording details of doctors' client visits, reporting in at the end of each visit, following predetermined procedures if doctors become uncontactable or do not check in when expected, and ensuring that they carry a duress alarm and/or mobile phone (GPS-linked if necessary) during visits.

Additional Security Measures

- 3.19 Additional security measures should be taken to protect doctors working late hours (for instance, in after hours surgeries), in settings where they are on their own or where emergency help is not quickly available and in places where drugs are stored or being distributed. An example in relation to the latter would be to reposition drugs cabinets so that they are within view of as many staff as possible during the course of their work to deter violent incidents.

Post-incident Management

- 3.20 Post-incident management activities should include post-incident support (such as first aid, medical attention, and incident debriefing), incident reporting, and incident investigation activities which include recommendations to help prevent future recurrence.

4. Monitoring and Evaluation

- 4.1 Continuous monitoring and evaluation of outcomes needs to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.

Resources

Some useful sources for more information include:

- ACT WorkCover (2000), *Guidance on Workplace Violence* (available through www.workcover.act.gov.au).
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