

Review of MENTAL HEALTH ACT 1986

ANF (Vic Branch) response to Consultation paper – December 2008

Q1. What, if any, additional reform objectives should be reflected in the new Act?

We support the reform objective of ensuring the new Act appropriately protects human rights in the light of the Victorian Charter of Human rights and responsibilities, with the stated aims of strengthening or improving:

- The Act's role in promoting recovery, with the primary consideration being ways in which diverse needs of individuals could be better recognised and respected in the Act
- Patient participation in treatment and care decisions, including placing patients at the heart of the Act
- The existing rights-based approach to involuntary treatment and care.
- The effectiveness and accessibility of mechanisms to oversee treatment and care.
- The Act's responsiveness to the needs of families and carers.

Q2. What principles, departmental objectives and functions should the new Act include?

The stated principles, department objectives and functions are supported:

- An explicit recognition in the principles that treatment should be voluntary wherever possible and that any decision about a patient must take into account the patient's views, beliefs and values to the greatest extent practicable.
- A principle that mental health services protect rights, minimise interferences with them and promote rehabilitation and recovery
- A function to support development of mental health services to assist carers and facilitate the provision of information, education and support to carers.

Q3. How should mental illness be defined in the new Act?

The current definition, as per Section 8(1) of the Mental Health Act 1986 is adequate.

Q4. What conditions should be excluded from the definition of mental illness in the new Act?

The exclusions as per Section 8(1) of the Mental Health Act 1986 should be included in the new Act

***Q5. If separating the involuntary treatment process into three stages is supported:
(a) What should be the grounds for each order? (b) What should be the duration of each order? (c) Should there be any restrictions on the kinds of treatment that can be given under each order?***

We support the separation of the involuntary treatment process into stages, so that a diagnosis may be made, or the order found to be unwarranted.

The grounds for:

- the assessment order should be as per Clause 8(1) *Criteria for involuntary treatment* of the current Act
- second and third stage orders should typically be progressed once a diagnosis has been made.

Q6. *How should the new Act address the issue of a person's capacity to consent to treatment in the grounds for an involuntary order?*

An aspect of the review process should include a consideration of the adequacy of the common law test, and whether a set of criteria/guidelines to assist clinicians to determine whether a person has capacity to consent.

It appears that currently this critical issue is made according to individual professional decision making. A set of objective criteria to determine capacity "competence" could only serve to enhance the decision making.

Whether the Act should include this set of criteria/guidelines is a matter for further consideration. They may be better dealt with in the same way as other clinical guidelines.

Q7. *How, if at all, should the new Act define what constitutes capacity to consent to treatment?*

Given this is a pivotal matter, and one which may have life changing consequences for the individual in question, as stated above, consideration should be given during the review process to arriving at a set of criteria/guidelines to assist in determining capacity. Whether capacity can be universally defined is not known. Definitions would need to be considered, and tested/validated.

Q8. *What requirements, if any, should the new Act contain for deciding whether or not a person has capacity to consent to treatment?*

If there were to be a definition of what constitutes capacity in the new Act, then the requirements for deciding whether or not a person has capacity to consent to treatment would be meeting the substance of the definition, ie *a person is deemed to have capacity if they have been assessed as meeting the following criteria.....*

Q9. *In what circumstances, if any, should the new Act permit a person to be placed on an involuntary order where the person has capacity to consent and is refusing treatment?*

This review should consider the concept of the person's best interest. If there were sufficient checks and balances in place (for example, authorisation by two psychiatrists), and if

- The person has a serious mental illness and
- If the treatment is not provided immediately there will be deterioration of the person's condition and
- If treatment is not provided immediately, there will be a significant risk to the person and/or others and
- In the opinion of the authorising psychiatrist, and the person's family, carer or nominated other,

an involuntary order is in the patient's best interest, then the person could be placed on an involuntary order.

The new Act could also include exclusion criteria as an additional safeguard to ensure the rights of the individual are protected as much as possible.

Q10. *How should the new Act address the issue of the seriousness and immediacy of risk in the grounds for an involuntary order as they apply to: (a) The person? (b) Others?*

The new Act should include the proviso that the treatment is likely to be effective, as well as requiring that the treatment is necessary in order to prevent serious/imminent/significant risk to self and/or others.

Safety should not be compromised in attempts to arrive at a right's based approach.

Q11. *How should the new Act address the issue of 'immediate treatment' in the grounds for an involuntary order?*

The current wording should remain. While determining immediacy may indeed be difficult for the psychiatrist and Board, the criterion of the person's mental illness requiring immediate treatment should remain.

Consideration could be given to developing guidelines to assist in determining immediacy.

Q12. *How should the new Act address the issue of the 'least restrictive manner' in the grounds for an involuntary order?*

Given this issue is adequately addressed in the current, it should remain unchanged in the new Act.

Q13. *What requirements, if any, should the new Act contain to enable involuntary patients to provide informed consent to a wider range of psychiatric treatment?*

The new Act should adopt the requirements of the Scottish Mental Health Act (Care and Treatment), as cited in the Consultation document.¹

Q14. *If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?*

The new Act should adopt the appropriate clauses of the Scottish Mental Health Act (Care and Treatment), as cited in the Consultation document².

Q15. *What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist should the new Act include?*

The new Act should adopt the safeguards inherent in the Scottish Mental Health Act (Care and Treatment), as cited in the Consultation document.³

¹ Consultation Paper, December 2008: Review of the Mental Health Act 1986, p.23

² Consultation Paper, December 2008: Review of the Mental Health Act 1986, p.23

³ Consultation Paper, December 2008: Review of the Mental Health Act 1986, p.23

Q16. *Should the new Act include a best interests requirement in relation to treatment decisions made by the authorised psychiatrist?*

The new Act should include a *best interests* requirement in relation to treatment decisions made by the authorised psychiatrist.

Such a requirement should include the persons own preferences, assuming there is an Advanced Statement and the opinions and concerns of family, carer or nominated person.

Q17. *How should the new Act address the issue of children and young people who do not have capacity to consent to treatment due to their mental illness?*

The new Act should make special provision for children and young people, whereby the parent or guardian may consent to psychiatric treatment where the child cannot due to their level of maturity, rather than their mental state.

While these children and young people should continue to be treated as voluntary patients, the new Act should enable them to have the benefits of the safeguards that apply to involuntary patients, such as automatic external review, educated and experienced mental health professionals such as a psychiatric clinical nurse consultant or nurse practitioner, in consultation with the treating team.

Q18. *What requirements, if any, should the new Act contain for clinical reviews of involuntary patients subject to: (a) An involuntary treatment order? (b) A community treatment order?*

Given a key role of the treating team is monitoring the ongoing need for involuntary treatment, there may be reasonable grounds for the Act not specifying the frequency of clinical reviews.

Q19. *In what circumstances, if any, should the authorised psychiatrist consent to the annual examination of an involuntary patient?*

There may be grounds for legislating that the examination of the mental and general health of an involuntary patient occurs more frequently than annually. As the document states: *The annual examination is critical for a number of reasons. It provides an opportunity to identify any medical conditions that require treatment and ensures any side effect of psychiatric treatment can be identified and appropriately managed*⁴.

Medications prescribed for mental illness have potentially serious adverse side effects and interactions, and require close and constant monitoring and review.

The general health status of many persons with mental illness, regardless of whether they are an inpatient or otherwise, is often suboptimal, due to risk factors such as cigarette smoking, alcohol and other substance misuse, poor diet, inadequate exercise and self neglect, and may require more frequent attention in order to facilitate early diagnosis of cardio vascular disease and malignancies. The 2001 Western Australian Study: *Duty to*

⁴ Consultation Paper, December 2008: Review of the Mental Health Act 1986, p.24

*Care: Preventable Physical Illness in People with Mental Illness*⁵ states these people are often less likely than the general population to access healthcare, and further, when they do, they are often given a dismissive reception.

However, whether the frequency of such examinations needs to be legislated is worth considering. Given the forthcoming integrated mental health strategy, it would be reasonable to expect that all workers across the full spectrum of mental health would recognise their duty of care to ensure adequate, timely and appropriate access to medical care.

Q20. *What obligations, if any, should the new Act impose in relation to reporting results of annual examinations?*

The reporting of the examinations should occur at the local level, as well as to the Chief Psychiatrist.

Q21. *If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?*

It is not clear why there may be a case for separate grounds for Community Treatment Orders. The criterion of least restrictive environment must be at the heart of a right based approach to care.

Q22. *What should be the duration of a community treatment order in the new Act?*

The new Act should retain the ground of least restrictive environment. However, community treatment orders probably require more frequent review, because of the fact the person does not have the same interaction with – and proximity to – the treating team.

Such reviews should be undertaken as a routine part of the persons care and treatment, and should be undertaken by suitably educated and experienced mental health professionals such as a psychiatric clinical nurse consultant or nurse practitioner, in consultation with the treating team.

Q23. *Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?*

The new Act should make reference to *the person's best interest*. It is difficult to make a universal statement claiming that a particular type of treatment should not be given under a community treatment order. Rather, if it is deemed in the persons best interest that the treatment (or an aspect of the treatment) should be given as an inpatient because of a range of physical, health and social/cultural considerations, then admission to a mental health facility should be contemplated, and discussed with the patient, family, carer or nominated person.

Q24. *What obligations, if any, should the new Act impose in relation to informing a patient's family, carer or nominated person of a patient's rights?*

⁵ Lawrence et al, 2001: Duty to Care: Preventable Physical Illness in People with Mental Illness, Uni Western Australia, p 102

The Act should be used as a vehicle to maximise opportunities for the patient's family, carer or nominated person to become *competent* in the issue of the rights of patients. We use the word *competent* because the health service and health professionals need do more than simply handing written material to families/carers/nominated persons. Such people need a strong understanding of human rights and patient's rights, so that they may apply such knowledge as required.

Further, the Act should include the current requirement that each service has a patients' rights statement/charter clearly posted in general areas so that carers, family and nominated person are able to view them at any time. Included should be direction of where to go/who to contact should they have any questions or concerns.

Q25. *If a nominated person scheme is considered necessary, how should the new Act address this?*

ANF (Vic Branch) supports the introduction of a nominated person scheme as it is a means of maximising the patient's understanding of the notion of patient's rights, and how this interfaces with involuntary admission and treatment.

The Act should provide for a patient to nominate a person to receive information about their care and treatment, and about patient's rights.

Such a nomination should be respected unless there are grounds for believing this person's involvement may be harmful to the patient and/or others.

Q26. *What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?*

We support the introduction of the requirement for a funded independent support person (however titled), the key responsibility of the position being that of advocacy.

Q27. *What requirements, if any, should the new Act contain to assist voluntary patients to understand and exercise their rights?*

The new Act should contain a requirement that a statement of rights be given to all patients, whether they are involuntary or voluntary.

However, we consider that merely giving a patient written material may not be sufficient. The new Act should ensure that the *goal* of improving patients' awareness and understanding of their rights is enshrined in the legislation, with consideration being given to health services employing a patient advocate, whose role would be to assist patients, where necessary, maximise their awareness and understanding of their rights.

Again the issue is about ensuring the patient is *competent* in their awareness and understanding of their rights, treatment, treatment options, and other related matters that may facilitate recovery.

Q28. *What requirements, if any, should the new Act contain to address issues of: (a) Patient involvement in treatment planning? (b) The content of treatment plans?*

There may be some merit in referring to Care and Treatment Plans – *care* being a more holistic term, incorporating nursing and other health professionals' involvement in the patient's illness and recovery. Treatment is frequently regarded in terms of pharmaceutical and ECT, and may not encompass the therapeutic interventions (and their effectiveness) of psychiatric nurses, social workers, psychologists and occupational therapists.

The new Act should contain a statement about the purpose of the treatment/care plans, ie to improve communication between the treating team and the patient. It should contain brief, concise statement about the treatment and care to be provided to the patient and the establishment of a partnership with the patient. It should also specify the relationship between the Treatment/care Plan and the Individual Service Plan.

While it may be outside the Act, a code of practice about the development of treatment and care plans should be developed to ensure a consistent statewide approach. All treatment/care plans should highlight the patient's rights.

(a) patient involvement in planning

Clearly the wishes and preferences of the patient must be taken into consideration when the treatment/care plan is first developed, and when it is being reviewed.

(b) the content of the treatment/care plan

At a minimum, the plan should include:

- An outline of treatment and possible side effects
- Identification of possible alternative regimens and their efficacy, strengths and weaknesses

However, consideration should be given to the content of such plans to be contained in guidelines, rather than in legislation.

Q29. *What additional requirements, if any, should the new Act contain to ensure the effectiveness of treatment plans?*

Treatment plans should include a discharge process, all aspects of the patient's needs, including medical, psychosocial, social, spiritual and cultural. Further, they need to include of the presence of co morbidities and or dual diagnosis, other risk factors (smoking, gambling, poor diet) and their likely impact on the recovery process.

Q30. *If an advance statement scheme is considered necessary: (a) What requirements should the new Act contain to ensure their effectiveness? (b) In what circumstances, if any, should the new Act allow an advance statement to be overridden?*

Matters relating to Advance Statement schemes should not be included in the Act. The availability and utilisation of Advance Statement should be available *as an option* to all. The new Act may need to include *the requirement* to respect Advance Statements where they have been completed.

The Act should make reference to *in the patient's best interest*. If the psychiatrist and other members of the treating team and family, carer or nominated other believes the wishes and instructions contained in the Advance Statement would not be in the patient's best interest (ie may be harmful) then clearly it could not be executed.

However, we do not consider the requirement that Advance Statements should/must be overridden when there are reasons to believe their execution could cause harm, should be in legislation. Health professionals are governed by professional standards and codes of ethics and practice, which should be sufficient for ensuring the *do no harm* principle prevails.

Q31. *How should the new Act regulate and monitor:*

(a) Premises on which ECT is provided?

The stats quo should be maintained

b) Persons who administer ECT?

The stats quo should be maintained

Q32. *How should the new Act address the issue of a person's capacity to consent to ECT?*

The review document states that 95% of all ECT treatment of involuntary patients was consented to by the authorised psychiatrist on the basis that the involuntary patient was unable to consent to the treatment.⁶

In other words, only 5% of involuntary patients were able/were deemed to be able to provide consent for ECT. This is indeed worrying – and begs the question. How realistic is the requirement of informed consent of involuntary patients who are deemed to require ECT?

Clearly this matter is directly related to earlier questions about the patient's capacity to consent, and the way in which the Act will define capacity to consent. The criteria needs to be the same as that which defines and determines capacity to consent generally (see responses to earlier questions, specifically, to questions 6,7,8 and 9)

Q33. *If oversight of consent to ECT is considered necessary, what type of scheme should the new Act contain?*

Advanced statements may have role to play here. In the event the patient did provide informed *refusal* (ie specifically refused ECT in an Advanced Statement), the authorising psychiatrist's decision with regard to the patient requiring ECT should be subject to external review.

⁶ Consultation Paper, December 2008: Review of the Mental Health Act 1986, p.37

Q34. *How, if at all, should the new Act regulate provision of ECT in an emergency?*

Given the provision of informed consent not being required *if the nature of the mental disorder that a person has is such that the performance of the electroconvulsive therapy is urgently needed*⁷ is rarely, if ever used⁸, it should be removed.

This would send a clear message to patients and their families that the concept of informed consent - regardless of qualifying statements such as *urgent* and/or *emergency* - is paramount.

Q35. *How should the new Act address patient participation where ECT is proposed?*

We support the suggestion in the Consultation Paper, ie a recognition that when a patient is unable to consent to ECT, they may require further support, and, information would be provided to a nominated (by the patient) person, with the aim of assisting the patient's more effective participation in decision making and ability to raise concerns about treatment.

Q36. *What additional safeguards, if any, should the new Act contain where ECT is proposed for a young person?*

As a minimum, the provision of ECT on young people should only be on the direction and authorisation of a Child and Adolescent Psychiatrist. The informed consent of the individual's family, carer or nominated person must be obtained.

Q37. *How, if at all, should the new Act regulate physical restraint?*

The new Act should define physical restraint, and contemplate its use: it seems improbable that *mechanical* restraint could be utilised unless the patient is *physically* restrained in the first instance.

The new Act should require physical restraint to be subject to the same reporting obligations as mechanical restraint and seclusion.

Q38. *How should the new Act address the grounds for mechanical restraint and seclusion?*

We support and endorse all initiatives by the Department of Human Services and individual mental health services relating to the trialling and introducing of new therapeutic approaches to managing acutely unwell patients.

It is worth stating that ANF (Vic Branch) has a Zero Tolerance (Occupational Violence and Aggression) Policy – see Appendix 1 of this submission. The stated aim of the Guidelines is *to provide guidance to employers, nurses and others in the healthcare industry, to assist*

⁷ Mental Health Act 1986, section 73, p. 120

⁸ Consultation Paper, review of the Mental Health Act 2006, p. 39

them to implement strategies to prevent/reduce occupational violence and aggression based on the ANF (Vic Branch) Zero Tolerance Policy⁹.

We acknowledge the potential inherent tension between a rights based approach and a zero tolerance approach to occupational violence and aggression. However, it is a critical issue, and one which impacts directly on the capacity of the current and future workforce in mental health settings.

With this in mind, we support the concept that restraint should only be used as a last resort when other less restrictive options have been tried, or considered and excluded, and *where it is necessary to protect the person or others from immediate or imminent risk to health or safety.*¹⁰

Q39. *What obligations should the new Act impose on the authorised psychiatrist in relation to authorisation of mechanical restraint and seclusion?*

The obligations relating to authorisation for restraint and seclusion should remain unchanged, as they are adequate for the purpose stated above, ie *to protect the person or others from immediate or imminent risk to health or safety.*

Q40. *What obligations should the new Act impose in relation to the clinical monitoring of secluded or mechanically restrained patients?*

The current obligations contained within the Act of (i) continuous observation by a registered nurse or registered medical practitioner, and (ii) review at intervals of not more than 15 minutes by a registered nurse are adequate. However with regard to mandated intervals at which the patient must be examined by a registered medical practitioner, Clause (1E) should be removed, as it has the potential to lessen the safeguard inherent in Clause 1(D) (c) of the Act.

Q41. *Should the new Act require mechanical restraint or seclusion to end 'immediately' when the grounds for their use are no longer met?*

We support this proposal, and also support the suggestion that there is clarification of the purpose of the mandatory clinical review procedures in order to ensure restraint and seclusion are ended immediately upon cessation of the person meeting the grounds for their use.

Q42. *If regulation of physical restraint is considered necessary, should the new Act: (a) Authorise persons to exercise these powers? (b) If so, who should be so authorised?*

For the obvious reasons of prevention of harm to both patient and others, it is important the Act does include the regulation of physical restraint.

All direct care staff, regardless of regulation, need to be able to provide physical restraint in order *to protect the person or others from immediate or imminent risk to health or safety.*

⁹ Australian Nursing Federation (Vic Branch): Zero Tolerance (occupational Violence and Aggression) Policy, reviewed 2006

¹⁰ Consultation Paper, December 2008: review of the Mental Health Act 1986: p44

Clearly to attempt to physically restrain a person without the competence to do so could escalate the situation, and could lead to harm to self, the person and others. Minimum mandatory training in this area needs to be available for those in direct patient care.

While indeed it may be onerous to implement, the Act needs to make mention of physical restraint and the need for its regulation. It has been 'the elephant in the room' for long enough and a rights based approach must tackle the less pleasant aspects of our mental health system.

Q43. *If the physical restraint, mechanical restraint and seclusion of voluntary patients is considered necessary in the new Act: (a) On what grounds? (b) For what duration? (c) Subject to what safeguards?*

The consultation paper addresses this issue well. In the event of voluntary patients requiring restraint or seclusion *to protect the person or others from immediate or imminent risk to health or safety*, then the same regulations and process need to apply. Given this, it is imperative that there are prescribed processes to ensure the immediate review of the patient's voluntary status.

Q44. *What additional safeguards should the new Act contain for the effective regulation of restraint and seclusion?*

There should be a legislative obligation to notify a carer or nominated person and the external monitoring body. Care planning, and advanced statements involving the person and their carer or nominated person would assist greatly in the management – and perhaps prevention – of the need to utilise restraint and seclusion.

Q45. *(a) How soon after the making of an involuntary order should the new Act require external review? (b) How frequently thereafter should the new Act require external reviews of involuntary orders?*

The World Health Organisation recommendation that involuntary orders should be automatically reviewed in three days of being made, and six months thereafter should be required in the new Act.

Should a staged approach be introduced, consideration needs to be given to the timeframes of external reviews so that they are in accord with the timeframes of the staged approach.

Q46. *What type of external body, what kind of proceeding, and what powers should the new Act contain for: (a) External review soon after the making of an involuntary order? (b) Subsequent external reviews of involuntary orders?*

The current arrangement of a 3 person (legal member – chair; a psychiatrist; and a person representing the views and opinions of members of the community) tribunal for external reviews soon after the making of an involuntary order appear adequate, and should apply for subsequent reviews of involuntary orders.

Q47. *How should the new Act address issues of patient participation in external review?*

Before one can provide a reasonable response to this question, the issue of why the participation of involuntary patients (whether by attendance or representation) is so low needs to be addressed. The barriers need to be overcome. Certainly for some the effort and cost of retaining a lawyer may be prohibitive. Consideration should be given to the establishment of a funded scheme for legal representation, available to all patients. It is difficult to contemplate the introduction of a rights' based approach if the current barriers to independent advocacy are not identified and addressed.

While outside the scope of legislation, strategies that have the goal of the patient's participation in external review becoming standard practice should be developed.

Q48. *How should the new Act address issues of participation by families, carers or nominated persons in external review?*

The new Act should require that family members, carers or nominated persons be notified with reasonable notice of hearings, assuming there was no indication this may be contrary to the wishes of the patient.

The Act could refer to Advance Statements and where they exist, take into account the patient's wishes with regard to the presence of nominated others at the external review.

If there were no advance statements then the authorised psychiatrist should be able to request the presence of nominated others if it were deemed to be in the patient's best interest, and if the patient were in agreement.

Any indication by the patient that they did not wish such persons to be in attendance should be acknowledged and respected.

Q49. *How should the new Act address issues of participation by members of the treating team in external review*

The Act should state that if the authorised psychiatrist considered it to be in the patient's best interest, and if the patient was in agreement, then there should be participation by members of the treating team in external review.

Q50. *Should the new Act incorporate the functions of the existing psychosurgery Review Board within the functions of the external body that reviews involuntary orders?*

Before the answer to this question is determined, there should be a meta-analysis of the available research on this controversial intervention.

It seems remarkable that the question is about how best to incorporate the functions of the existing Psychosurgery Review Board for administrative reasons, and *not* about whether the Act should prohibit psychosurgery, as is now the case in some other jurisdictions.

- Q51.** *(a) What monitoring functions and powers should the new Act contain?*
(c) What type of body would be most effective in performing these monitoring functions and powers?

The new Act should contain the broad monitoring functions and powers of the Chief Psychiatrist. However, there should be a requirement to respond in a timely manner to areas of concern.

The publication of data in annual reports and of clinical guidelines plays a vital role in encouraging greater professionalism and improving clinical practice.

In the quest for a rights' based approach to mental health care, there is no logical imperative for the new Act to establish a mental health commission, or appoint a mental health commission.

Victoria currently has a Health Services Commissioner (HSC) whose responsibility it is to investigate complaints in all Victorian Health Services. Given the forthcoming Mental Health Strategy is committed to an integrated service, a separate Commissioner for Mental Health would not sit well with the strategy.

The office of the Chief Psychiatrist plays a key pivotal role and should be maintained for clinical guideline development and review and service provision improvements. There may be merit in establishing an independent body to perform the role currently undertaken by community visitors. The role of such a body should be clearly stated as being to ensure that all patients within Victoria's mental health service are informed of their rights and are supported in the exercising of their rights. (This should not be their role per se – but rather that of the health professionals working within the system. Rather, theirs is one in ensuring care and treatment is administered within a human rights paradigm).

They should work collaboratively with the Health Services Commissioner to investigate complaints from patients, families, carers and nominated others. The paragraph at the top of page 62 of the Consultation paper captures what we consider to be critical, ie. "... to proactively visit mental health services on a frequent and unannounced basis to meet with patients. Such visits are focused on informing and assisting patients to exercise their right and assisting service and system improvement rather than on inspector type regulatory functions"¹¹.

- Q52.** *If publishing of information obtained through monitoring functions is considered necessary: (a) What publishing requirements should the new Act contain?*
(b) In what other ways should the new Act require that information obtained through monitoring is used to improve patient wellbeing and achieve service improvement?

The new Act should require all information that would be of assistance in improving patient care and recovery, ie. all information that may inform clinical practice should be published, in a de-identified form, for example:

- (a) The quality/clinical improvement themes from coronial recommendations received by the Chief Psychiatrist.

¹¹ ¹¹ Consultation Paper, December 2008: review of the Mental Health Act 1986: p51

- (b) Investigations of sentinel events and the recommendations.
- (c) Clinical guidelines
- (d) Outcomes of investigations of the Health Services Commissioner. Such investigations and their outcomes should be written from a quality improvement perspective, and offer strategies to enhance clinical care within a human rights paradigm.

**Q53. (a) What death review functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these death review functions and powers?**

- (a) The new Act could legislate the review of sudden and unexpected deaths of involuntary patients providing it is for the stated purpose of acting promptly to prevent similar deaths or other problems occurring within mental health services or elsewhere. If this were to be included, criteria relating to “promptly” would need to be included. The absence of such criteria may result in little more than a duplication of the coronial investigation.
- (b) The body most effective in performing such reviews should be one established by the Victorian Health Services Commissioner.

Q54. If the establishment of a clinical leadership role is considered necessary, what functions should the clinical leader perform?

ANF (Vic Branch) notes the existence of the Senior Nurse Adviser, and acknowledges the importance of this role in terms of leadership, and contribution to policy development at the departmental level.

Q55. If giving legal force to clinical guidelines or codes of practice is considered necessary, what should be the implications of non-compliance?

If as the consultation document claims, many clinicians are unaware of the content and effect of the clinical guidelines, then greater effort needs to be made in ensuring clinicians are aware of these and other important codes and guidelines that inform and guide our practice.

Clinical guidelines and codes of practice should be subject to on-going review, with amendment as necessary. They are more dynamic documents than is legislation, and compliance by education and professional development is likely to be more effective than by embedding compliance in legislation.

Q56. What requirements, if any, should the new Act contain in relation to local complaint systems?

The new Act should contain requirements similar to that of the Northern Territory – ie. that mental health services are:

- i) required to report bi-annually about complaints received and any changes made to prevent recurrence;
- ii) required to establish complaints procedures that aim to resolve complaints wherever possible and promote quality improvement; and

- iii) required to notify complainants about their complaints procedures and about the progress of a complaint at regular intervals¹².

Clearly, for such reporting to be effective, relationships between the health service and the HSC would need to be developed.

- Q57.** *(a) What complaints functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these complaint functions and powers?*

The new Act should outline a complaints process that is simple and transparent, and is underpinned by the principles of natural justice and procedural fairness.

While the Consultation document on page 67 outlines the shortfalls of the HSC with respect to dealing with complaints from mental health patients and for the family, carer or nominated person, urgent consideration needs to be given to overcoming such shortfalls¹³.

It appears the regulatory framework is already in place, and with some adjustments to the HSC's staffing profile (so that they employ people with mental health expertise) and altering some requirements (for example, accepting oral as opposed to written complaints), it presents a far more preferable option to establishing an entirely new and separate-complaints body.

- Q58.** *What requirements, if any, should the new Act contain to support patients to make complaints?*

The new Act should ensure the patient's carer or nominated person has access to information/education about the notion of advocacy, and its associated responsibilities.

Further, the Act could contain a patient complaint "lodging" process/procedure

- Q59.** *What requirements, if any, should the new Act contain to ensure that information learned from complaints is used to promote service improvement?*

Recognising that complaints are one aspect of the continuous improvement process, we consider the Act should not contain requirements to ensure information learned from complaints is used to promote service improvement. While complaints should be analysed, the findings published, used to identify shortcomings within the system, with a view to finding strategies to address such shortcomings, such quality improvement process does not need to be enshrined in legislation.

- Q60.** *In what circumstances should the new Act permit disclosure of information to families and carers without patient consent?*

The new Act should state that clinicians directly involved in the patient care seek the person's permission to disclose information about care and treatment.

¹² ¹² Consultation Paper, December 2008: review of the Mental Health Act 1986: p68

¹³ ¹³ Consultation Paper, December 2008: review of the Mental Health Act 1986: p68

Until such time as consent is granted, then clearly some information must be disclosed to the family and carers so that they may have an understanding of the person's condition and its likely progress in order to better fulfil their role as carers.

Clinicians need to have a sound understanding of the legislation, so that they are able to work within the Act's requirements regarding the potential difficult relationship between the patient's right of confidentiality and the family/carers' right to understand and provide the care.

There needs to be a mechanism in place so that, for example, clinicians understand that, under the Act, they may disclose information only to those providing ongoing care. Given there is anecdotal evidence that some clinicians consider only family members and carers who live with the person in question are providing care, there needs to be immediate steps to rectify this misconception.

Access to ongoing education about the legislation will enable clinicians to practise less defensively. They will feel more comfortable to embrace the broader definitions of family and carers.

The Act should not be changed to accommodate the alleged poor understanding of some clinicians.

Q61. *What key events should the new Act require disclosure of information to a patient's family, carer and any nominated person without patient consent?*

The new Act should not *require* disclosure of information without patient consent.

The notions of *in the patient's best interest* and *to protect persons from immediate or imminent risk to health or safety* need to be utilised, allowing the clinician to determine which information should be disclosed, and when.

Q62. *In what additional circumstances, if any, should the new Act require disclosure of information to guardians?*

The status quo should prevail.

Q63. *In what circumstances, if any, should the new Act allow a guardian to consent to the disclosure of information about a patient?*

The status quo should prevail.

Q64. *(a) What service providers, if any, should receive identified information without a patient's consent? (b) If so, in what circumstances should they receive identified information without a patient's consent?*

Sharing of information between related services may facilitate the patient's recovery, and certainly ease the various administrative burdens. However without the patient's consent, such information sharing would be a betrayal of the patient's rights.

If we are to introduce rights based mental health legislation, then practitioners will need to be given ongoing professional development about working within the paradigm of patients' rights.

If the patient does not consent to the sharing of identified information, then it must not be shared, or provided.

Importantly, the development of the new Act needs to be cognisant of the Health records Act, and its criteria relating to the sharing, provision and receiving of information.

The two Acts need to be in harmony, so that there is no confusion on the part of health professionals who work within the legislative framework of each.

APPENDIX 1

AUSTRALIAN NURSING FEDERATION (VIC BRANCH) POLICY

ZERO TOLERANCE (Occupational Violence and Aggression) POLICY

(Adopted December 2001)

(Reviewed August 2003)

(Reviewed April 2006)

The Policy

The Australian Nursing Federation (Victorian Branch) believes that:

Nurses have a right to work without being subjected to violence and aggression and therefore endorses a **Zero Tolerance** (Occupational Violence and Aggression) Policy¹⁴.

Definition

Occupational Violence and Aggression is defined as:

“Any incident in which employees are abused, threatened or assaulted in circumstances arising out of, or in the course of their employment. It includes:

- Verbal, physical or psychological abuse.
- Threats or other intimidating behaviours.
- Intentional physical attack, such as hitting, pinching or scratching.
- Aggravated assault.
- Threats with a weapon or objects.
- Sexual harassment and sexual assault.”

Violence and aggression may involve an actual or implied threat to safety, health or well being. Threats can be *internal* eg; Patients, residents, their relatives, or *external* eg; intruders.¹⁵

Principles

1. That under the Victorian Occupational Health and Safety Act 2004 all employees have a right to work in an environment that is safe and without risks to health.
2. That the human and financial cost of occupational violence and aggression is unacceptable and can be prevented.
3. That the effective prevention and management of violence and aggression in the healthcare industry is in the interests of all concerned, including employers, staff, patients, and the community.

¹⁴ This Policy focuses on patient violence and aggression, or that perpetrated by patients' relatives, visitors, or intruders to the workplace. Workplace bullying and harassment is recognised by ANF (Vic Branch) as a form of occupational violence and aggression which specifically involves conflicts between employees, and is dealt with under the ANF (Vic Branch) Workplace Bullying and Harassment Policy.

¹⁵ Guidelines for the Prevention of Occupational Aggression and Violence in the Health Industry, Victorian Health Industry Occupational Health and Safety and WorkCover Advisory Committee, Melbourne, November 1995.

4. That a Culture of Acceptance will not be tolerated and that healthcare employers will actively support a policy of zero tolerance towards violence and aggression in their workplace. Establishing an environment which actively encourages and supports incident reporting, is crucial to achieving cultural change.
5. That a risk management/systems approach is the most effective means of preventing/reducing occupational violence and aggression, involving the establishment of policies and procedures for hazard identification, risk assessment, and risk controls.
6. That the participation of and consultation with staff and their representatives, including the ANF (Victorian Branch) and occupational health and safety representatives, is critical to the effective implementation of such policies and procedures in the workplace.
7. That staff education and training is an essential component of the effective prevention and management of occupational violence and aggression. Education and training must be adequate, appropriate and ongoing to deal with workplace violence and should involve not only direct and non direct care staff but also universities and colleges and later consultation with consumers and carers.
8. That the environmental layout, lighting and ambience of the workplace should be conducive to reducing the incidence of violence and should reflect Australian Standards in design for the security of health care facilities, and the principles of Crime Prevention through Environmental Design (CPTED). Security will be enhanced with the presence of trained security personnel and adequate surveillance equipment and personal protection devices. In accordance with the requirements of the Occupational Health & Safety Act 2004, occupational health and safety, including security, must be taken into account in the design of buildings or part of buildings used as a workplace.
9. That patients have a right to be cared for by adequately trained staff and in an appropriate and safe environment. Staffing levels and skills mix should reflect the care needs of the patients.
10. That Critical Incident Management policies and procedures should be part of every workplace and should be fully utilised.
11. That research and statistical data should be collected and maintained to be used in the development of future policies, codes, standards and guidelines.
12. That the effective prevention and management of occupational violence and aggression requires a collaborative approach between all parties, including the ANF (Vic Branch), the relevant employer associations, the Department of Human Services, the Victorian WorkCover Authority, the Victoria Police, and the Department of Justice.

AUSTRALIAN NURSING FEDERATION (VIC BRANCH) POLICY
ZERO TOLERANCE (Occupational Violence and Aggression) POLICY
INTERIM GUIDELINES
(October 2001)
(Reviewed January 2006)

The ANF (Victorian Branch) acknowledges that occupational violence and aggression is a complex issue. The following guidelines are an interim guide to the ANF (Victorian Branch) Zero Tolerance (Occupational Violence and Aggression) Policy.

1. INTRODUCTION

The last decade has seen a global trend towards increasing workplace violence in the health care setting. Factors which have contributed to this in Australia are: a significant restructuring of the health industry, changes in service delivery which have not kept pace with safety issues, and government funding cuts which have resulted in serious nursing shortages.

A report by the Australian Institute of Criminology in 1999, identified the health industry as the most violent industry in Australia¹⁶. The report found that nurses are amongst the most at risk groups in terms of workplace violence. Nurses recorded the second highest number of violence-related workers compensation claims after security guards, and ranked higher than prison and police officers.

The report also found that assaults in psychiatric facilities tended to be associated with periods of "elevated level of activity", such as meal times, visiting times and transporting of patients. A study by the International Council of Nursing found that the most vulnerable groups of nurses are those working in isolated or rural settings, emergency departments, community settings and in mental health¹⁷. An area of increasing concern is the incidence of violence and aggression from residents and relatives in aged care settings - particularly dementia/behaviour units.

A recent survey of 2400 nurses, conducted by the University of Tasmania, found that 64% of respondents had experienced physical or verbal abuse at work. 1 in 10 nurses had left a nursing position at some time during their careers because of physical or verbal abuse¹⁸

As a result of the increasing level of occupational violence and aggression against nurses and other health care workers, there is now a world wide trend towards the implementation of zero tolerance policies. In September 1998 the National Health Service (NHS) in the UK adopted a "Zero Tolerance" policy for the health industry, which included provision for police liaison and reporting of incidents involving violence and aggression¹⁹.

¹⁶ Violence within the Workplace, Australia Institute of Criminology, Research and Public Policy series. No 22 p46 1999

¹⁷ "Zero-Tolerance in the workplace", Kai Tiaki Nursing, New Zealand, p9, 1999

¹⁸ Scoping Workplace Aggression in Nursing [SWAN] Research Report, Farrell G, et al, University of Tasmania, Tasmanian School of Nursing, April 2003

¹⁹ www.nhs.uk/zerotolerance.htm

In July 2003, the NSW Department of Health also released its Zero Tolerance Policy and Framework Guidelines “in response to violence in the NSW Health Workplace”.²⁰

In Victoria, a Government Taskforce was established to review and make recommendations in relation to the prevention and management of occupational violence against nurses. The Victorian Taskforce on Violence in Nursing released its Final Report and Recommendations in March 2006. All Victorian healthcare facilities will be expected to implement policies and strategies to prevent occupational violence and bullying in accordance with the recommendations of the Report.

1.1 Legislation

Under the Victorian Occupational Health and Safety Act 2004 employers are required to provide a healthy and safe work environment for their employees. This includes ensuring the security of the staff, patients and others. Employers are also obliged to put into place effective policies and procedures to prevent and manage violence and aggression in the workplace. Employees also have a duty under the Act to take reasonable care for their own health and safety or of others that may be affected by their acts or omission and they must co-operate with their employer to comply with requirements under the Act.

Under the provisions of the Victorian Crimes Act 1958, offenders may be liable to prosecution for assault if an incident of aggressive or violent behaviour occurs.

1.2 Cultural Attitudes

A 1999 study by the Trade Union Congress (TUC) in the UK²¹, showed that nearly one third of all nurses had been violently attacked or abused at work by patients or patients’ friends and relatives (these figures do not include attacks by intruders). It also found significant under-reporting and a passive acceptance of violence and aggression by nurses, the industry and the community. According to Mayhew, C, official statistics significantly under-state the extent of occupational violence, with nurses formally reporting only 10-20% of incidents²². Cultural attitudes that support under-reporting and acceptance of violence as “part of the job” must change if we are to effectively address this issue.

1.3 Human and Financial Cost

The human and financial cost to the nursing profession and the health industry are significant, including potential workers compensation costs and impact on premiums. The indirect costs of injury are also potentially significant, and include the cost of sick leave/absenteeism and staff replacement. In human terms, the cost to injured nurses may include the loss of their chosen career, the impact on families and relationships, and reduced quality of life, with the victims and their families often left to bear the physical, psychological and financial scars.

²⁰ “Zero Tolerance: Response to Violence in the NSW Health Workplace – Policy and Framework Guidelines”, NSW Health, July 2003, www.health.nsw.gov.au

²¹ Trade Union Congress “Violent Times”, January 1999

²² Mayhew, C, “Preventing Violence Against Health Workers”, Paper presented at WorkSafe Victoria Seminar on Violence in the Health Industry, 13 June 2003

Legal Cases

In a recent case in NSW a judge awarded \$583,000 to a nurse who was nearly strangled to death by a patient in a psychiatric unit at Campbelltown Hospital in 1996²³. The New South Wales District Court in January 2001 found that the South West Sydney Area Health Service had failed to provide a safe system of work, that there was an ad hoc patient risk assessment practice in the unit, a lack of experienced staff in the unit at all times, and numerous problems with the alarm system. As a result of the assault, the nurse was unlikely to ever return to her chosen career.

In another case, a hospital receptionist in Burnie was awarded damages of \$339,408, after she was assaulted by a drunken man who threatened to slit her throat. The woman, who developed post traumatic stress disorder, sued her employer for damages for her injury. In awarding the damages, the Supreme Court of Tasmania found that senior staff at the hospital had known of the risk of assault by persons affected by liquor coming to the hospital reception during night shift, and found that the employer had not taken reasonable steps to prevent injury from the foreseeable risks. The Court found that the employer should have installed remote control locks on the exterior doors, and a perspex barrier could have been erected on top of the reception counter to prevent physical contact with staff. In awarding her the money, the Court found that the employer's negligence had "shattered the life of a middle-aged, active and energetic woman and turned her into a lethargic, anxious and timid person"²⁴.

In two separate prosecutions by the NSW Work Cover Authority, Sydney Area Health Service was fined \$180,000²⁵ and the Department of Community Services²⁶ was fined \$285,000 for breaches of the Occupational Health & Safety Act following violent assaults by patients. In both cases, the obligations of the employer to ensure the health and safety of employees was found to be paramount.

The increasing level of violence and aggression against nurses has contributed to the problem of lowered morale and staff losses from the industry, at a time when the industry and the community can ill afford it.

Patients, visitors and others are also at risk from violent and aggressive incidents, as evidenced by incidents which have occurred in recent years, including the stabbing murder of an elderly resident by another resident in a Victorian nursing home.

The aim of these guidelines is to provide guidance to employers, nurses and others in the healthcare industry, to assist them to implement strategies to prevent/reduce occupational violence and aggression based on the ANF (Vic Branch) Zero Tolerance Policy.

²³ ABC News Online, www.abc.net.au/news/newslink/nat/newsnat-19jan2001

²⁴ *Glozier v State of Tasmania*, Australian Occupational Health & Safety Law 53-713, reported in CCH Occupational Health and Safety Update - 4/4/01, Newsletter 3/2001

²⁵ "OH&S Obligations are Absolute", *The Adviser*, No. 61, May 2002, Service Industry Advisory Group, pp 1-3, www.siag.com.au

²⁶ Legal cases presented by Corrs Chambers Westgarth at WorkSafe Victoria Seminar – Violence & aggression in the Health Industry, 13/6/03

2. STRATEGIES TO PREVENT/REDUCE OCCUPATIONAL VIOLENCE AND AGGRESSION

Healthcare employers should develop policies and procedures and fund implementation strategies to prevent and manage occupational violence and aggression. This includes procedures for reporting of incidents to police, and co-operating with police to lay charges and pursue prosecutions where appropriate.

Policies and procedures must be developed in consultation with staff, their ANF representatives and occupational health and safety (OHS) representatives. Under the policy, employers will be required to implement systems to identify hazards, assess and control the risks associated with Occupational Violence and Aggression, incorporating the following strategies:

2.1 Policy and Procedures

Each employer must:

- Adopt a written policy of zero-tolerance, providing a strong message that violence and aggression will not be acceptable at any level.
- Ensure the policy is endorsed by Board of Management/senior executive management level. The policy must be communicated to and adopted by all staff at all levels of the organisation. It is critical that the policy be actively supported by all levels of management and the medical staff.
- Establish workplace committees, including direct care staff and OHS representatives, to oversee the development and implementation of the zero tolerance policy and procedures.
- Develop and implement systems/processes to identify hazards, assess and control risks associated with occupational violence and aggression.
- Develop patient risk assessment tools. Patients must be assessed by nursing staff in conjunction with other healthcare professionals as appropriate, prior to admission (or if this is not practicable, as soon as possible after admission), to identify any aggressive or violent behaviour. Any known prior aggressive behaviour by patients or relatives should be documented. Assessments should include the physical environment, including community settings. These assessments should be incorporated into the patient care plan.
- Ensure regular review of patient care plans including any changes or deterioration in behaviour.
- Establish effective procedures for staff handover/communication, to ensure the communication of any changes in behaviour, incidents or potential areas for concern at handover.

2.2 Placements/Admissions

- Employers must ensure that patients are placed appropriately and that the facility can meet the needs of the patient. This must be determined prior to admission wherever practicable. If the facility cannot provide appropriate care, including appropriate facilities and a safe physical environment, or does not have staff with the relevant skills and qualifications, the patient should not be admitted, or should be transferred to an appropriate facility as soon as practicable.
- If difficulties placing a patient are encountered, management must contact the Department of Human Services (or the Commonwealth Department of Health and Aged Care for placement of elderly patients in residential care) who should arrange placement to a more

appropriate facility when necessary to ensure suitable care for those patients, as well as the protection of staff and others. If this is not immediately possible, management must implement interim measures to reduce the risk as much as possible, including the provision of additional specialist staff until such time as an appropriate place is found.

2.3 Staffing Levels, Skills and Qualifications

Employers must:

- Ensure a sufficient staffing level and skills mix is available on all shifts to facilitate a safe work environment. Staff shall have appropriate skills and qualifications according to patients' needs.
- Make available or engage specialist staff where necessary, so as to ensure appropriate case management of patients with identified behavioural or psychiatric problems, eg provide nursing staff with specialist skills in dementia care to care for dementia patients/residents.
- Minimise use of agency or casual staff, as staff turnover often leads to de-stabilisation.
- Seek the co-operation of medical management, medical practitioners, including psychiatrists, to ensure appropriate medical treatment and management for patients.
- Ensure that nursing students are not placed in known risk situations.

2.4 Security Systems

- All healthcare management should conduct a security risk assessment/audit in conjunction with staff and their OHS representatives in order to determine the security needs of their facility. The risk assessment/audit should include an assessment of the need for on-site trained security personnel, effective emergency alarm and communication systems, and the physical environment (see Section 2.6 below). Assessments/audits should be conducted with the assistance of qualified, experienced consultants with expertise in the prevention and management of violence and aggression and security.
- Security personnel shall be appropriately trained and shall be in sufficient numbers to reflect the needs of the organisation.
- All hospitals with emergency departments and/or psychiatric units shall have on site 24 hour security personnel. A visible presence of on-site security personnel is an important component of a preventative (deterrent) strategy, and also ensures timely response to critical incidents when they occur. The number of security personnel employed shall depend on the size and needs of the facility, but shall cover all shifts and be adequate to ensure effective security of staff, patients and others at all times.
- Security personnel shall be dedicated to the job of providing security for the facility and shall not be in conjunction with other duties.
- As a minimum, all healthcare managements (other than hospitals with accident and emergency departments and psychiatric units) must ensure that there is linkage to security personnel and/or the police to respond to incidents when they occur.
- Security/police response times should be less than five minutes.
- In the case of remote/rural areas, where there is delayed access to police, management/the Board of Management must develop a response plan which can be activated by staff when urgent assistance is required because of violence and aggression.
- Where nurses work in a community setting, there must be a system to document and identify the location, time of departure and expected return, of staff conducting home visits. The system must be actively monitored and supervised by management.

- All nurses working in community settings undertaking home visits where there is a known history or identified risk of violence and aggression, must work in pairs or be provided with a security escort. Nurses working in community settings must at all times be provided with appropriate communication devices linked to security personnel or the police (see Section 2.7).

2.5 Emergency Response Teams

All healthcare managements must:

- Establish written policies and procedures for Emergency Response to violence and aggression.
- Establish multi-disciplinary emergency response teams consisting of dedicated staff trained in emergency response.
- Ensure staffing levels are adequate and appropriately trained emergency response staff are on duty on all shifts to ensure effective emergency response can occur.

2.6 Physical Environment

Health care managements must ensure that the physical environment of the workplace promotes security of staff, patients and others, and shall include the following strategies²⁷:

- Workplace design must ensure that public access to all areas of the workplace is minimised. Access to the facility must be by one main entrance and security should be placed at this entrance if necessary.
- Signage of entrances for public access shall be clear and well lit.
- Security controlled entrances and exits; eg – swipe card or keypad access.
- Building structure shall be such as to provide protection against intruders, eg reinforced glass for doors and windows shall be used for entrances by emergency departments, psychiatric units, community mental health services, or other facilities and areas where potential or actual security risks are identified. Entrance doors should be supported by reinforced steel. Security blinds or screens should be fitted on doors and windows wherever appropriate to reduce visibility to intruders.
- Closed circuit television (CCTV) must be installed wherever practicable (after consultation and agreement with staff) for monitoring, eg reception/waiting areas, corridors, blind spots, areas where additional supervision of patients and others may be needed.
- New buildings, grounds and car parks shall be sited and designed to reduce opportunistic attacks. Car parks within close proximity of the workplace shall be provided for staff employed on evening or night shift. Car parks, grounds and other external areas shall be well lit. Where staff do not have access to car parks within close proximity to the building, the employer shall provide a security escort for staff on evening or night shift, when entering or leaving the building.
- Isolated areas (internal and external) shall be well lit.
- Reception areas in emergency departments shall be well lit, comfortable and spacious, with comfortable furniture provided for patients and their relatives. Surroundings, including colours, should be calming. This will reduce frustration and aggressive tendencies. A TV, toys and games for children, and access to drinks and food should be available.

²⁷ Adapted from Guidelines for the Prevention and Management of Occupational Aggression and Violence in the Victorian Health Industry, Victorian Health Industry Occupational Health and Safety and WorkCover Advisory Committee, Department of Health and Community Services, November 1995

- Furniture should be fixed to the floor and visitors or clients should not be able to access objects which can be used as missiles or weapons.
- Facility reception and waiting areas should be easily identifiable and accessible to patients and visitors. The design and layout of reception and waiting areas should incorporate the following:
 - Reception staff are to be provided with a clear view of all persons in the waiting area. The activities of clinical staff should not be visible from the waiting room or reception area.
 - It is preferable that counters be fitted with vertical glass partition otherwise counters are to be high enough to deter an adult climbing over them, and wide enough to make it difficult for persons to come into physical contact with a staff member. Vertical partitions should be provided to allow for some privacy when people are discussing private matters with staff.
 - Each counter must be fitted with a duress alarm, with the alarm button hidden from view, eg under the counter.
 - The ends of the counter are to be closed to prevent clients walking into staff areas. Entry doors should be full height and fitted with security access, and a one way viewing panel. There should also be an escape door to allow easy escape by staff into the staff area. The door to the staff area should be secure.
 - Reception areas should have a second self-locking door for emergency retreat.
- Separate treatment and interview rooms must be provided to isolate distraught or emotionally disturbed patients, families or friends. Treatment and interview rooms must be fitted with two doors opposite each other to allow easy escape by staff; one door should lead in from the public area and the other from the staff area. The door to the staff area should be secure.
- Treatment and interview rooms must be fitted with duress alarms and glass viewing panels on doors to allow observation by colleagues.

2.7 Communications and Alarm Systems

- Effective alarm and communication systems must be installed in all healthcare facilities to enable staff to be alerted to respond to any threat.
- Communication/alarm systems shall be appropriate to the needs of staff and the nature of their work. Staff working alone or in isolation, in remote areas, or in community settings, shall be provided with communication devices such as mobile phones (including, where necessary, satellite phones), personal duress alarms, portable two-way radios, etc.
- Nurses and their representatives shall be consulted in the selection of alarm systems and communication devices.
- Systems/devices should be trialed before purchase to ensure that they meet the requirements of staff and patients.
- Systems/devices must be regularly checked, serviced and maintained in accordance with the manufacturer's instructions in order to ensure that they are always fully operational.
- Communication devices and alarm systems must be linked to a security firm and/or police (See Section 2.4 above).

2.8 New Buildings, Renovations or Refurbishments

- Employers must consult with nurses and their OHS representatives when undertaking construction of new buildings, renovations, refurbishments or extensions, to determine

security needs, including design/layout issues and communication/alarm systems. Such consultation shall occur at the design/planning stage, and shall be ongoing until completion of all works and relocations and including a post-occupancy review. Working parties or committees consisting of management and employee representatives (including direct care staff and OHS representatives), must be established to oversee these processes.

2.9 Education and Training

- Violence prevention education and training programmes shall promote Zero Tolerance for workplaces including verbal, non verbal threats and assault.
- Training must be provided to all staff, including medical staff and management, and must include part-time, bank and casual staff. The degree of training shall be determined by the work area of the staff concerned, but shall include specific training for staff working in specialist/high risk areas.
- Training shall be compulsory for all staff and must be provided in paid time.
- Training shall be competency based and linked to learning outcomes.
- Training shall be practical and relevant and shall include:
 - Workplace policy and procedures for managing and preventing violence and aggression, including emergency response procedures.
 - Understanding of employer and employee obligations under OHS legislation.
 - Awareness of any relevant industry guidelines, codes of practice, standards, etc.
 - Predicting, and identifying triggers for violent and aggressive behaviour.
 - Understanding of the importance of risk assessment and reduction.
 - Evasive self defence techniques.
 - Defusing aggressive situations.
 - Communication skills.
 - The importance of incident reporting.
 - Post incident management, including procedures for incident reporting, investigation and follow-up, critical incident debriefing and counselling.
 - Legal duty of care and the use of reasonable force.
 - Making police statements, laying charges and prosecutions.
- Training must be provided as part of induction and orientation to all new staff, including specific training for specialist/high risk areas.
- Refresher training must be provided at regular intervals thereafter, and at least yearly.
- Training must be provided by suitably qualified and experienced trainers.
- Where agency staff are engaged to fill temporary vacancies (eg sick leave), management must ensure that, wherever practicable, agencies which provide violence and aggression training to their staff are utilised.

2.10 Information and education of patients and their families

- The employer shall provide written information and advice to patients and their families regarding the zero tolerance policy and procedures of the workplace in relation to violence and aggression. This shall include information about the consequences of repeated violent or aggressive behaviour.
- Posters advising members of the public about the policy should be displayed in the workplace.

2.11 Reporting to Police

Police support and co-operation is critical to the effective implementation of a zero tolerance policy. The employer shall establish a relationship of mutual collaboration, co-operation and response.

The employer shall:

- Regularly liaise with local police and inform police when incidents occur.
- Support staff in making police statements, laying charges and encourage police prosecutions wherever appropriate.
- Liaise with relevant authorities, eg the Department of Human Services, Department of Health and Aged Care, to ensure implementation of the zero tolerance policy.
- Institute agreement/contracts for patients and their families regarding compliance with the policies and procedures of the workplace, and the consequences of non-compliance.

2.12 Incident Reporting

Employers shall promote and support a culture of non-acceptance of workplace violence and aggression. This includes:

- Encouraging the formal reporting of all incidents, whether resulting in injury or not.
- Acting immediately following an incident to ensure the safety of all staff and others.
- Investigating all incidents. Investigations should be conducted in consultation with the relevant staff and their OHS representative(s) where practicable, and appropriate measures put into place to prevent further injury to staff and others. A feedback loop should be established to keep staff and their representatives informed of the progress of investigations and the actions to be implemented.
- Verbal aggression and threats by patient or others must be documented/ flagged in patients' notes.
- Incident form copies should be placed into patients' records.
- Employees must report all potential or actual incidents to management as part of their responsibility to reduce occupational violence.

2.13 Critical Incident Stress Management

- All staff will be offered critical incident debriefing after any incident or when requested. Critical Incident debriefing shall be provided as soon as practicable, but at least within 12 to 72 hours after the incident occurs.
- Debriefing shall also be offered and made available at a later time, as the need may arise some time after the incident.
- Each employer shall have a nominated debriefer, but the employee may opt to use a debriefer of his or her choice. Providers of debriefing services shall be appropriately qualified and trained.
- The employer is responsible for funding debriefing services.
- Nurses may access debriefing services of their own volition and there is no compulsion on the part of the nurse to attend debriefing. One person's experience of the same incident may differ markedly from another, ie one may be affected and the other not.
- In addition, professional counselling is to be offered and made freely available to those individuals who require ongoing assistance in dealing with the incident.

- Employees have the right to claim WorkCover for medical expenses/treatment and time off work relating to injury or illness arising from an incident involving workplace violence and aggression.
- The employer shall ensure that all staff are aware of critical incident debriefing programmes, employee assistance programmes, and ‘Care of Self’ education.

2.14 Communication Between Referring Agencies / Transfers

All health care facilities or agencies shall establish procedures to communicate information in an appropriate manner to other agencies to alert them to identified or known aggressive or violent behaviour of clients. This includes when transferring patients between wards within a facility. Such information should be provided and managed with appropriate regard to Privacy, Anti-discrimination and other relevant legislation.

2.15 Monitoring and Review of Policies and Procedures/Systems

The employer shall establish procedures for the ongoing monitoring, evaluation and review of policies and procedures, such as to ensure their effectiveness. Reviews shall be undertaken regularly, and shall be conducted in conjunction with staff and their OHS representatives, and are to be undertaken by the relevant workplace committees/working parties.

3 RESEARCH

Research should be undertaken into the causation, frequency, weapons used, demographic and outcome sequelae, the impact on staff members and organisations and the larger consequences for the nursing profession and the health industry. Statistical data and incident reporting for future use by the health industry, universities and member representative organisations will assist in the identification of trends and planning for the future needs of the industry to maintain safety in the workplace.

3.1 Data Base

The employer shall establish a database for the purpose of monitoring staff health, analysis and research in relation to occupational violence and aggression.

4 UNIVERSITIES AND COLLEGES

The ANF (Vic Branch) will work with universities and colleges to encourage them to provide training and education in the prevention and management of occupational violence in all undergraduate-nursing courses.

5 SPECIALIST (HIGH RISK) AREAS

The ANF (Victorian Branch) will work in consultation with key stakeholders including, where applicable, Special Interest Groups, to develop additional specific guidelines as appropriate for specialist/high risk areas including, *but not limited to*:

- Emergency Departments
- Psychiatric Units
- Aged Care

Disability Services
Nurses working in Isolation, Remote and Rural Areas
Sole Practitioners
General Practice
Community Nursing.

6 ANF (VIC BRANCH) COMMITMENT

The Australian Nursing Federation (Victorian Branch) is committed to undertaking an ongoing education and awareness campaign aimed at the health industry to underpin the Zero Tolerance policy. The ANF (Victorian Branch) will work in co-operation with employers, the Department of Human Services, Victoria Police, the Victorian WorkCover Authority and the Department of Justice, in the development and implementation of an Industry Code of Practice.

Notes:

- In these Interim Guidelines the words patient/resident/client, and hospital/community/residence are interchangeable.
- These Interim Guidelines should be read in conjunction with the following:
 - ANF (Vic Branch) Zero-Tolerance (Occupational Violence and Aggression) Policy
 - ANF (Vic Branch) Policy on Occupational Health and Safety
 - Victorian Taskforce on Violence in Nursing – Final Report, November 2005
 - Guidelines for the Prevention and Management of Occupational Aggression and Violence in the Victorian Health Industry - Victorian Health Industry Occupational Health and Safety and WorkCover Advisory Committee, November 1995
 - AS 4485.1-1997 Security for Health Care Facilities Parts 1 & 2
 - Victorian Occupational Health and Safety Act 2004
 - WorkSafe Victoria Guidance Note for the Prevention of Bullying and Violence at Work, February 2003
 - Industry Guidelines for the Prevention and Management of Occupational Violence and Aggression in Victoria's Mental Health Services, December 2004.
 - WorkSafe Victoria Guidelines for Inspectors for the Prevention and Management of Occupational Violence and Aggression in Emergency Departments and Psychiatric Units, 2005.

Reference should also be made to the Crimes Act 1958 and amendments.

Workplace Bullying and Harassment:

These Interim Guidelines focus on patient violence and aggression, or that perpetrated by relatives, visitors, or intruders to the workplace. Workplace bullying and harassment is recognised by the ANF (Vic Branch) as a form of occupational violence and aggression which specifically involves conflicts between employees, and is dealt with under the ANF (Vic Branch) Workplace Bullying Policy.