Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services

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Statement of commitment

These interim standards are the result of significant collaboration between the Health and Community Services Union (HACSU), the Australian Nursing Federation (ANF) Victorian Branch, the Victorian Hospitals Industrial Association (VHIA) and the Department of Human Services (DHS) to develop mental health specific interim standards for the prevention and management of aggressive behaviour and post-incident support of staff.

These interim standards have been developed as a result of Australian Industrial Relations Commission (AIRC) proceedings in C No 35606 of 2000.

Staff who work in Victoria's mental health services have been identified as a group at substantial risk of being assaulted in their workplace[1]. The management and prevention of occupational violence and aggression towards mental health staff is now acknowledged as a major occupational health and safety (OH&S) issue with clinical, fiscal and legal ramifications[2]. The parties to these interim standards acknowledge this and the outcome demonstrates their commitment to working together for the improved safety of staff.

Mental health services are encouraged to undertake audits using these interim standards in a consultative and collaborative manner with their staff, in particular OH&S representatives, consumers and carers.

As part of this process it is expected that risks will be identified, prioritised and strategies developed to minimise incidents.

The collaborating organisations encourage mental health services to review their current policies on the prevention and management of occupational violence and aggression. They should also utilise these interim standards in further developing a safe environment for staff, consumers and visitors.

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1 Australian Institute of Criminology Research and Public Policy Series No 30.

2 Scafani, M, Developing a Clinical Violence Prevention and Intervention Plan for Psychiatric Mental Health Settings, Journal of Healthcare and Quality, March/April 2000.

Contents

1 Introduction

Occupational violence and aggression in mental health services is a growing problem that has long-term ramifications for mental health workers and for employers. These interim standards encourage and support the industry to take a proactive approach to occupational violence through the use of appropriate systems that emphasise hazard identification, risk assessment and control.

These interim standards acknowledge that mental health practitioners work in an environment where aggressive behaviour can occur in response to a number of issues, such as the perceived unmet needs of an individual. Aggressive and violent behaviour may occur when people are acutely ill, or have impaired judgement and may misinterpret their environment.

Mental health services, as part of their role, provide care to consumers who may not always provide, or be able to provide, consent to receive care and treatment. One of the responsibilities of staff is to observe and monitor the consumer's mental state and their acceptance of treatment. This means that staff may bear the brunt of the consumers' and/or relatives' frustration and anger about their treatment.

In this context, preventing and managing aggressive and violent behaviour has become an essential requirement for all mental health services, whether inpatient or community-based. To meet their responsibilities, agencies must establish a working environment in which the consumers' needs can be met while minimising risk to the health and safety of employees.

The challenge of ensuring the safety and welfare of employees, consumers and the community requires an integrated care and risk management approach. Critical to an integrated system is the provision of environments and systems that aim to avoid or mitigate risk and provide mental health practitioners with the appropriate knowledge, attitudes and skills to prevent and manage occupational violence and aggression.

1.1 Changes in the mental health services environment

The role and extent of staff working in Victoria's mental health services has changed significantly over the past decade. The move to community-based services means that many consumers who would previously have been hospitalised are now being managed in the community.

The introduction of case management and the provision of care in the least restrictive environment have exposed staff to risks previously not encountered. Any response to the issue of preventing and managing occupational violence and aggression should be mindful of these changes.

Adverse social behaviour and the prevalence of problematic substance use have had a significant impact on the incidence of occupational violence.

Significantly, substance use adversely affects the consumer's mental illness and can also increase the risk of aggressive verbal and physical behaviour to staff and others.

Research shows as many as 50 per cent of the mentally ill population also have a substance use problem[3]. Co-morbidity in consumers is seen by mental health practitioners as the main factor for the increase in violence and aggression in both inpatient and community settings.

3 Agnus B. Hatfield, Dual diagnosis: substance abuse and mental illness, www.schizophreniz.com

1.2 Acknowledging the problem

Occupational violence and aggression within mental health services has in the past been accepted as 'part of the job'. This belief and associated culture has led to under-reporting of incidents and the acceptance of violence in the workplace.

Management should acknowledge the problem of occupational violence and aggression not only by meeting their legislative obligations but also by demonstrating their commitment to best practices that protect everyone in the workplace from violent incidents.

Staff can support prevention measures by putting into action the policies and procedures developed to address aggressive behaviour. They can also help reduce violence risks by promptly reporting incidents. In turn, management should support and encourage staff to report incidents.

Because of the multifaceted nature of the issue, management, staff (including OH&S representatives) and consumers, where appropriate, should work together to develop strategies to prevent and manage the risk of occupational violence and aggression in the workplace.

1.3 What we know about workplace violence and aggression in the sector

There is a lack of information and data, often compounded by significant under-reporting of incidents, to accurately establish the true extent of workplace violence in mental health services.

A discussion paper prepared for the NSW Health Department Taskforce on the prevention and management of violence in the health workforce reviewed trends and noted that:

> The jobs at highest risk of client-initiated violence in the United States, the United Kingdom and Australia are: police, security and prison guards, fire service, teachers, welfare, health care and social security workers...Within the health sector a review of predominantly US research literature has identified nurses, psychiatrists, psychologists, social workers, mental retardation specialists, nurse's aids and substance abuse counsellors as being at particular risk.[4]

The issues paper on the proposed code of practice for the prevention of workplace bullying released by WorkSafe Victoria in 2001 noted that:

> For example, earlier this year media reports revealed the problem of assault against nurses in a number of Victoria's public hospitals. The articles reported that 864 Victorian nurses had been verbally abused or physically assaulted during the period January 1999 to October 2000. Nurses most at risk worked in emergency departments or psychiatric hospitals. This figure is likely to under-represent the actual numbers of assaults against nurses. One researcher found that 75 per cent of assaulted nurses do not officially report incidents as they fear lack of privacy and think they will be judged as unable to cope with their chosen profession.[5]

4 School of Industrial Relations and Organisation Behaviour, University of NSW, Occupational violence: types, reporting patterns and variations between health sectors, prepared for Taskforce on the Prevention and Management of Violence in the Health Workforce, August 2001, p. 8

5 Victorian WorkCover Authority, Issues Paper: Proposed interim standards for the prevention of workplace bullying, 2001, p. 8.

Claims data from WorkSafe Victoria indicates that violence related claims are increasing and that the average cost of such claims is at least $40,000. In the last three years the costs of assault claims only in the health sector has been $7.9 million.

Under these interim standards, employees are actively encouraged and supported by employers to report all occupational violence and aggression. Employers will be expected to collect and maintain data that will inform the development of future standards and programs.

1.4 What we mean by occupational violence and aggression

Occupational violence and aggression is an action or incident that physically or psychologically harms another person. It includes situations where staff and other people are threatened, attacked or physically assaulted within the workplace. Non-physical violence, such as verbal abuse, intimidation and threatening behaviour, may also significantly affect a person's health and wellbeing.

Occupational violence and aggression is defined, for the purpose of these interim standards, as:

> **any incident arising out of or in the course of employment in which staff are abused, threatened or assaulted verbally and/or physically.**

This definition covers assault by a person who may not be able to form intent, but is capable of violence.

2 The status of the interim standards

These interim standards have been developed to provide the industry with a framework and strategies to prevent and manage occupational violence and aggression and as a mechanism for ongoing implementation, monitoring and accountability within mental health services.

These interim standards should be read in conjunction with related legislation and policies.

In summary, these interim standards:

- provide practical guidance
- outline the current state of knowledge about managing occupational violence in mental health service settings
- will assist mental health services in complying with OH&S legislation
- should be followed, unless there is a better solution that achieves the same result or better.

Note: These interim standards should also be an evolving document that can be reviewed and changed through an agreed process, in the light of research findings and identified best practice examples.

2.1 Purpose of these interim standards

These interim standards aim to minimise and eliminate wherever practicable the risks of workplace violence in relation to the prevention and management of occupational violence and aggression within public mental health services, and to implement necessary controls and supports where total elimination of risk is not possible.

2.2 Scope of these interim standards

The interim standards apply to the prevention and management of occupational violence and aggression within mental health services.

Mental health services are defined as:

> *agencies that receive funding from the Department of Human Services, Victoria for the provision of mental health services to consumers of these agencies.*

2.3 Key principles underpinning these interim standards

These interim standards are based on the following key principles:

- Employers have a responsibility under current Victorian OH&S legislation to provide a safe workplace.
- Preventing risks to health, safety and wellbeing in the workplace is the most effective way to reduce injury and illness.
- Mental health services employers are committed to preventing and reducing occupational assault.
- Staff, consumers and carers, employers, OH&S representatives and industrial bodies will participate in initiatives to ensure that they are relevant and appropriate to the needs of the workplace.

- Staff have a responsibility under current legislation for their own safety and the safety of others within the workplace. Staff must cooperate with employers in meeting these responsibilities.
- These interim standards will be reviewed on a regular basis.
- Any strategy aimed at preventing and managing occupational violence and aggression needs to cover the full cycle of prevention, immediate response and recovery and review.

2.4 How these interim standards relate to the law

These interim standards have been developed with particular reference to the *Occupational Health and Safety (OH&S) Act 1985*. Note is also made of other relevant legislation including the *Crimes Act 1958* and the *Federal Workplace Relations Act 1996*.

Using these interim standards to develop programs will assist mental health services to comply with the requirements of the OH&S Act to provide a safe workplace, including safe systems of work. The Act provides the framework for the regulation of workplace health and safety. It imposes general duties on a range of key parties, including employers and employees. In imposing these duties, it aims to ensure that those with requisite authority or control over particular aspects of the working environment exercise that authority or control in a manner that is not harmful to the health or safety of any person.

The WorkSafe Guidance note on the prevention and management of bullying and violence in the workplace provides guidance relevant to the sector.

How occupational health and safety legislation can be applied in managing workplace violence

What the legislation says	What this means for developing strategies to reduce workplace violence
Occupational Health & Safety Act 1985 **Section 21 – duties of employers** (1) An employer shall provide and maintain so far as is practicable for employees a **working environment** that is safe and without risks to health.	**Working environment** Any aspect of the workplace itself, the work processes; including what is done and how it is done. This is clearly relevant when considering how to reduce occupational violence.
(2) Without in any way limiting the generality of sub-section (1), an employer contravenes that sub-section if the employer fails-	**Plant** Includes any machinery, equipment, appliance and tool, any component thereof and anything fitted, connected or appurtenant thereto.
(a) to provide and maintain **plant** and **systems of work** that are so far as is practicable safe and without risks to health;	**Systems of work** The available human, physical and financial resources to do the job safely. Includes staffing levels, rosters, work and practice protocols, training requirements and supervision. Considerations of plant and system of work have clear implications for safety in the workplace and strategies to reduce workplace violence.
(b) to make arrangements for ensuring so far as is practicable safety and absence of risks to health in connection with the use, handling, storage and transport of plant and **substances**;	**Substances** Any substance, such as a drug, and the need to safely store such substances so as not to create any risks to health.
(c) to maintain **so far as is practicable** any workplace under the control and management of the employer in a condition that is safe and without risks to health; The Occupational Health and Safety Act 1985 defines 'practicable' as having regard to: (a) the severity of the hazard risk in question; (b) the state of knowledge about the hazard or risk and any ways of removing or mitigating the hazard or risk; (c) the availability and suitability of ways to remove or mitigate that hazard or risk; and (d) the cost of removing or mitigating that hazard or risk.	**So far as is practicable** Taking steps to eliminate or minimise risks of occupational violence in the light of existing knowledge about occupational violence, its sources and ways of controlling it. Any consideration of cost and practicability should include consideration of the direct and indirect costs of injury and illness, including workers compensation costs and premiums, loss of skilled staff, and other costs associated with violence and aggression. 'So far as is practicable' will involve weighing up these factors.
(e) to provide adequate facilities for the **welfare** for employees at any workplace under the control and management of the employer (should be read in conjunction with the First Aid and Workplace Design codes); or	**Welfare** In the case of occupational violence, means providing first aid, counselling, incident debriefing and any follow-up action to minimise the severity of the effect of any incident on employees.
(f) to provide such **information, instruction, training and supervision** to employees as are necessary to enable the employees to perform their work in a manner that is safe and without risks to health.	**Information, instruction, training and supervision** Provision of training and information about how to manage workplace violence and the existence of appropriate supervision to ensure staff are protected.

Section 25 – Duties of employees

(1) While at work, an employee must:

(a) take reasonable care for his or her own health and safety and for the health and safety of anyone else who may be affected by his or her acts or omissions at the workplace, and

(b) co-operate with his or her employer with respect to any action taken by the employer to comply with any requirement imposed by or under this Act.

(2) An employee shall not:

(a) wilfully or recklessly interfere with or misuse anything provided in the interests of health and safety or welfare in pursuance of any provision of this Act or the regulations; or

(b) wilfully place at risk the health and safety of any person at the workplace.

Employees must:

- follow workplace practices and policy designed to reduce occupational violence and aggression risk
- report to management all incidents of occupational violence and aggression
- identify, report and document all risks of occupational violence and aggression to management and other staff through appropriate systems, such as during verbal handover, by notation and by alert flagging of clinical file and central database file.
- cooperate with management and OH&S representatives in the development and implementation of strategies to reduce occupational violence and aggression within the workplace
- actively monitor behaviour of consumers and be alert to signs of escalation to minimise and avoid such escalation
- increase skills and understanding by attending training provided by the employer
- take reasonable care while at work for their own health and safety and that of others and not knowingly place themselves or work colleagues and others at risks by their acts or omissions[6]
- refuse to work in a knowingly unsafe situation.

6 OH&S Act (Victorian) 1985

Recent legal cases applying OH&S law to workplace violence (1)

In April 2002, Sydney Central Area Health Service was fined $180,000 for failing to maintain a place of work that was safe and without risk to health under section 15(1) of the NSW *Occupational Health & Safety Act 1983* following a serious assault by a psychiatric patient on four nurses at Rozelle Hospital on 6 April 1997.

During the attack, the nurses were punched and kicked, and one male nurse became locked in a ward with the patient, who threatened him with a jagged shard of glass.

The court ruled that workplace safety legislation takes precedence over the *Mental Health Act 1986* if the Acts conflict in a situation where employees are in danger.

The presiding judge, Justice Schmidt said:

> There can be no doubt that in a situation where the choices facing the defendant are physical intervention in order to ensure that a patient is restrained from hurting others and a risk to the health, welfare or safety of employee, if such steps are not taken, the absolute obligations of s. 15 of the Act, require that the safety of employees be preferred.

In passing sentence, Justice Schmidt said the risk to safety by the presence of breakable glass in the hospital was foreseeable, and the absence of a designated controlled entry point for staff responding to a critical incident had placed one of the nurses at grave risk.

Recent legal cases applying OH&S law to workplace violence (2)

In 2002, the Department of Community Services (DOCS) was prosecuted by WorkCover NSW for breaches of the OH&S Act following a series of assaults on care staff by residents of a group home. The department was fined $285,000.

Features of the prosecution's case included:

- assertions that the group home had too many residents, an unsuitable resident mix, did not have enough space to manage escalating behaviour and was of poor design
- staffing levels were not adequate though additional staff were allocated after a number of incidents had occurred
- DOCS had failed to provide adequate emergency procedures and equipment in that there was no 'safe room', no duress alarms, the 'on call' system failed, no detailed evacuation plan and no access to mobile telephones on outings
- there was no risk assessment of behaviours and staff were not trained in the application of policies
- information, training and supervision was inadequate with team meetings not happening and ad hoc induction of new staff
- clients with a predisposition to violence were not safely managed, were not prevented from having access to hazardous objects such as knives and electrical appliances, and were not prevented from having access to substances, such as coffee, that may exacerbate behaviours
- adequate counselling was not provided after incidents
- client safety had not been ensured since clients were also being assaulted by others
- risks were foreseeable and obvious and despite this, risk control measures were not taken.

2.5 The importance of consultation in preventing occupational violence and aggression

Consultation can take place through a number of forums including elected OH&S representatives, OH&S committees or other agreed workplace arrangements. Whatever the arrangement for consultation, it is recognised that employee involvement improves decision making about occupational violence.

Employees should be encouraged to:

- assist in developing occupational violence policies and procedures
- raise any workplace violence concerns
- give regular feedback on how well the workplace manages problems associated with actual and potential violence
- help solve workplace management of violence and aggression.

3 Risk management approach to occupational violence and aggression

Under the OH&S Act, employers are required to provide and maintain, so far as is practicable, a working environment that is safe and without risks to health. This includes providing:

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

From a quality improvement perspective, efforts to address occupational violence and aggression within the workplace should encompass a comprehensive, planned and whole of service approach. This approach should change the traditional focus of facilities from a reactive approach to one of prevention and risk management. The employer, in consultation with staff and OH&S representatives, should assess risk and develop and implement risk controls.

Under the OH&S legislation and supporting guidelines[7], there are **three steps** that should be followed as part of the general duties applying to workplaces:

7 Practical guide to Victorian health and safety legislation, Glossary of Terms (xiv), Definition (P1-4) and General Provisions Relating to Occupational Health and Safety (P3-1), October 1998.

1 Hazard identification

Hazard identification – the process of identifying occupational violence hazards in the workplace that could cause harm to staff or others.

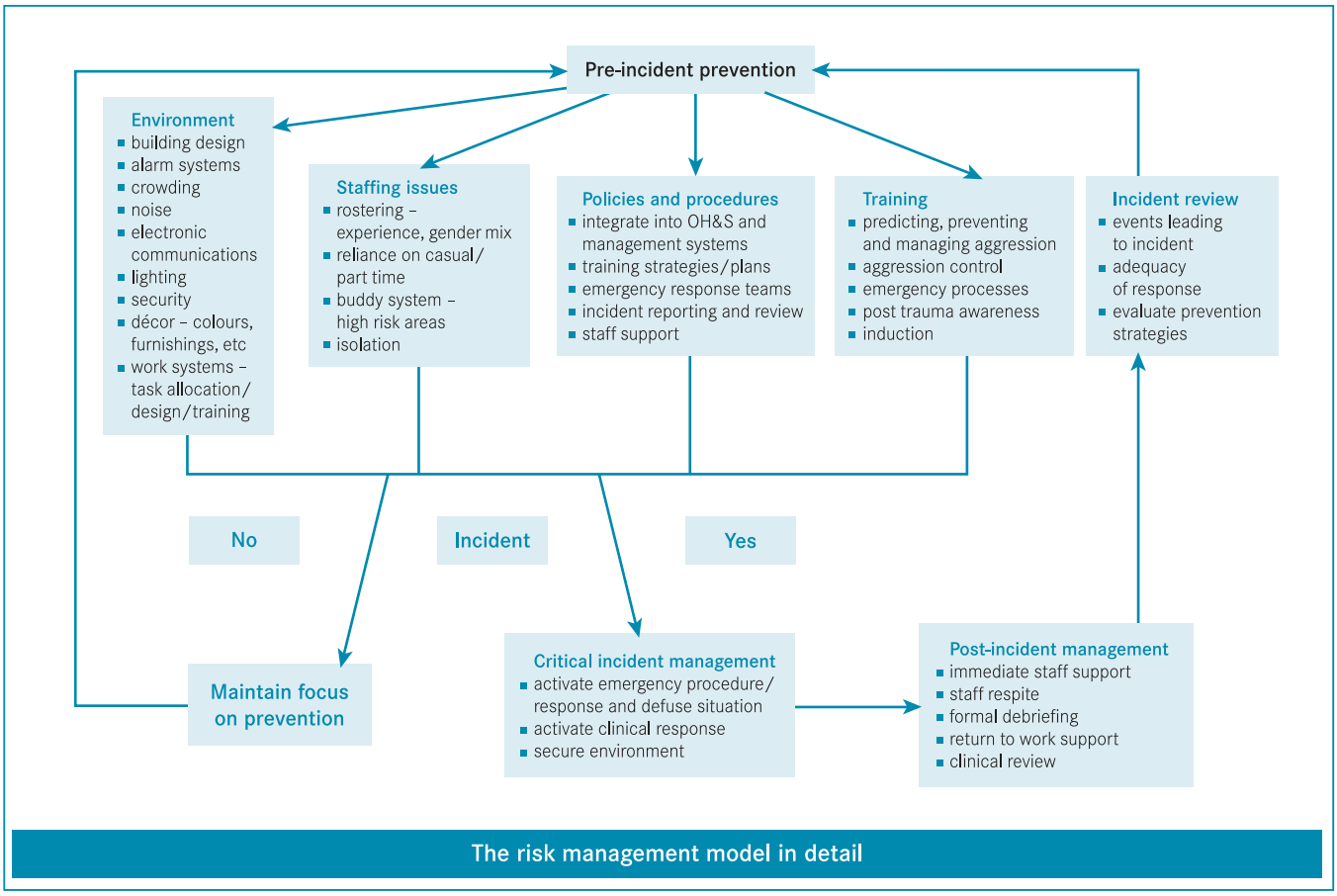
2 Risk assessment

Risk assessment – the process of assessing the risks associated with the hazard, including the likelihood of injury or illness being caused by that hazard, and identifying the factors that contribute to the risk.

3 Risk control

Risk control – the process of determining and implementing measures to eliminate or minimise workplace violence. The risk controls or prevention measures should address the factors identified in the risk assessment.

The risk management model below outlines incident prevention and management approaches.



The risk management model in detail

4 Hazard identification

Use this checklist as a starting point

Common workplace factors in violence and aggression in mental health services

Consumer profile

- dual diagnosis (typically mental illness and substance misuse)
- previous history of violence
- access to weapons.

Environmental

- lack of privacy
- lack of access to some open space
- austere and lack of home like environment
- cramped conditions
- uncontrolled work environment, for example home visits
- design and layout of building and surrounds not conducive to physical security of staff, clients and others.

Social

- boredom
- lack of opportunity to participate in therapy or social groups.

Organisational

- inexperienced or inadequately trained staff
- inadequate security and screening
- inadequate staffing
- inadequate personal protective equipment, for example, personal duress alarms/devices and communication systems
- organisational culture that accepts a level of harm to staff
- inadequate emergency response arrangements.

Methods

Inspections, surveys, incident reports, investigation and reviews should be used to help identify warning signs, patterns and trends of threats and violent acts that expose employees, consumers, visitors and others to harm.

5 Risk assessment

These risk factors increase the likelihood that occupational violence and aggression will result in injury.

A risk assessment should be carried out where any hazards are identified. The assessment should consider the factors that contribute to the risk of occupational violence and aggression and the severity of the risk in each case.

These risk factors need to be part of an ongoing risk management cycle.

When determining the level of risk, management, you should evaluate security requirements, systems of work, workplace design and training requirements.

Workplace violence and aggression risk factors in mental health services

Consumer profile

- evidence of violence warning signs (for example, paranoid delusions about others, violent command hallucinations, preoccupation with violent fantasies, denial of previous dangerous acts)
- relatives exhibit aggressive behaviour or have a history of doing so.

Environmental

- observation or sight lines impeded
- exits and entrances not within sight of staff
- inadequate signage and lighting (internal and external)
- inadequate management of entry and exit doors
- access to objects that could be used as weapons
- building materials, for example, glass.

Social

- sensitivity to disruptive events (personal care, treatment delays, noise, visits)
- anxiety resulting from delays in organising assessment, transport or admission of patient.

Organisational

- working alone or in an isolated situation
- lack of consistency in clinical communication about and to client
- lack of information transfer at shift changeover.

Methods

Planned risk assessment should consider how likely a workplace violence incident is for clients and staff. Secondly, the assessment should look at the likely consequences of an incident (who could be injured and how seriously?). Dynamic risk assessments need to be included as part of the case management plan and will interact closely with clinical practice.

6 Risk control

Framework for controlling occupational violence and aggression in mental health services

Risk control refers to measures to eliminate or minimise risk. These should include:

- policies and protocols
- modification to the physical environment, layout and design of the workplace
- equipment (alarm systems and communication devices)
- staffing levels and skills mix
- the need for security personnel
- staff training
- post-incident management and support.

6.1 Policies and procedures

Employers should ensure that policies and procedures are specifically developed to prevent occupational aggression and violence in conjunction with staff and OH&S representatives and, where appropriate, industrial representatives.

Policies and procedures should include:

- policy that acknowledges the risk of occupational violence and aggression within mental health services and includes identification, risk management and support strategies
- procedures for preventing and managing occupational violence and aggression, which include critical incident response protocols and post-incident debriefing and support
- policies that identify and address the issue of illicit substance use and the associated increased risk of occupational violence and aggression
- consultative mechanisms, for example, an occupational violence and aggression advisory committee should be established to oversee the development and implementation of strategies to prevent and manage occupational violence and aggression (such a committee should include representatives from management and staff, OH&S representatives, and industrial representatives)
- mechanisms for constant monitoring, evaluation and review.

Further guidance on policies and procedures is on the next page

What should be covered in an occupational violence and aggression policy?

- definition of occupational violence and aggression
- statement of responsibility on the part of the organisation
- commitment to preventative measures that protect employees from violent and aggressive behaviour
- commitment to encourage incident reporting and to support staff in any post-incident action
- commitment to consult and communicate with all stakeholders
- reference to the relevant mental health legislation
- reference to the relevant OH&S legislation and supporting guidance (for example, *WorkSafe Guidance note on the prevention and management of bullying in the workplace* and industry guidance as shown in the Reference section)
- statement of the aims of the policy
- identification of those responsible for ratifying, monitoring and evaluating the policy
- expectations and responsibilities of staff
- date of policy and date of review.

How to write effective procedures

A procedure is a written statement that answers the following questions:

- **What** has to be done?
- **How** does it have to be done?
- **Who** has to do it?
- **When** does it have to be done?

The format for the written procedure should meet effective workplace communication standards. The following plain English principles are recommended:

- get straight to the point
- use words familiar to the work group
- keep sentences short and simple
- use the active voice where possible
- make the procedures 'talk' to the users, for example, use 'you' and 'we'
- use conversational English.

Sample
Policy and procedure on emergency response

Policy and procedure manual

Unit	Section	Subject	page
	Emergency	Psychiatric emergency	

Policy statement

A psychiatric emergency is defined as an event in which an individual is behaving in a way that represents a significant risk to the safety of that individual and/or others in their environment.

Outcome standards

- The safety of patients, visitors and staff is not compromised.
- All clinical staff are skilled in the management of emergency procedures, including appropriate intervention and restraint techniques.
- There is minimum disruption to the treatment and management of patients.
- All necessary documentation is completed without delay.
- Debriefing is offered to all individuals.

Process standards

(Cross reference: seclusion, mechanical restraint and incident reporting)

- Where possible, the shift leader/senior clinician is responsible for deciding on the least restrictive intervention.
- Staff should engage individuals where possible and attempt to de-escalate situation.
- Staff should activate personal duress alarms when they believe assistance is required to manage the situation safely.
- Shift leader/senior clinician should ensure sufficient staff are available to manage the emergency and coordinate movement in the area.
- Shift leader/senior clinician allocates staff to remove persons not involved from the area.
- The shift leader/senior clinician present shall be responsible for advising staff that the emergency has been resolved and for primary responders to return to their units.

Sample
Policy and procedure on emergency response

Policy and procedure manual

Unit	Section	Subject	page
	Emergency	Psychiatric emergency	

Post-incident

- The shift leader/senior clinician shall be responsible for post-incident management, which may include the following steps:
  - prepare incident report – attach the incident running sheet if appropriate
  - the program manager shall forward a copy of the incident to the emergency response committee for a review
  - emergency response committee shall ensure that feedback is provided to clinical staff
  - complete Disease Injury Near Miss Accident (DINMA) form
  - prepare seclusion documentation
  - prepare case notes.
- Defuse persons involved in the incident. The shift leader/senior clinician or person conducting the defusing will determine if further intervention or debriefing is required. If so, advise the Critical Incident Stress Management (CISM) coordinator.
- Activate CISM.
- Identify actions to be taken to prevent/minimise risk of further incidents.

Written by: _____

Validated by: _____

Approved by: _____

Review date: _____

Reviewed by: _____

Review date: _____

6.2 Environmental considerations

Framework for controlling occupational violence in mental health services

There needs to be a balance between risk and risk management. An environment that is too restrictive will impact negatively on a therapeutic setting. Patients should feel comfortable and safe and able to express themselves in a verbal, rather than physical, manner.

Environmental considerations that diminish 'triggers' and look at basics such as space, design and layout of the workplace and lighting will do much to eliminate hazards for staff. Security and safety features must be included in the environment design. These should include, but are not exclusive to:

- Building design, décor and aesthetics.
- Security controlled entrances and exits, effective communication/alarm systems, monitoring and surveillance systems and devices, personal protective equipment (such as duress alarms, pages, mobile phones), internal and external lighting.
- Design and layout of the workplace conducive to the effective prevention and management of occupational violence and aggression should be considered in any proposed renovations and new building designs.
- Consultation with OH&S representatives and affected staff in relation to security and the environment should occur at the design and planning stages and be ongoing to completion of the building and renovations.
- Environmental factors that affect community workers providing care in private homes or the streets should be assessed for risk and intervention.
- Program of regular maintenance and upkeep of equipment and devices including mobile phones and vehicles where staff spend long periods driving.
- Faulty equipment is repaired quickly or replacement equipment is provided.

Further guidance on environmental considerations is shown on the next page

Sample
Audit checklist for environmental considerations

Some typical examples of design related issues are shown below.[8]

Reception area

- Is the reception area clearly marked?
- Is there a natural barrier, such as a deep reception desk, separating staff from patients/clients, relatives and the public?
- Is any glass barrier installed around reception desks made of shatterproof glass?
- Does the layout of the reception area allow staff to greet incoming patients/clients and make sure they are seen in order of arrival or appointment?
- Does the layout of the reception area make it easy to observe patients/clients?
- Are there any areas out of sight of staff where someone could deliberately hide?
- Is the reception area staffed at all times?
- Is there an alarm system?
- Does the receptionist sometimes work alone?
- Are there objects, tools or equipment in this area that could be used as weapons?
- Is anyone in the area responsible for handling cash?

Interview/treatment/counselling rooms

- Is access to the interview room controlled by locked doors?
- Is the room located in a relatively open area that still maintains privacy and confidentiality?
- Does the layout of the room and furniture permit workers to exit if threatened?
- Is a back-up exit available for emergencies?
- Does the room have an alarm system?
- Does the door have a window or is there an observable window to the room?

Pharmacy/medication room/treatment room/office

- Is there another way out for an emergency exit?
- Are furniture/counters arranged to both allow visibility and protect staff?
- Does the width/height of the counter/desk provide an appropriate barrier between staff and the public?
- Does the area have an alarm system?
- Do workers sometimes work alone? Do they know the appropriate emergency alert procedures?
- Are pharmacy staff required to handle cash?

8 Adapted from: Preventing violence in health care: five steps to an effective program Workers' Compensation Board of British Columbia, 2000.

6.3 Staffing considerations

Framework for controlling occupational violence and aggression in mental health services

Staff working in mental health services come from all areas and disciplines within the service. Safe staffing levels and appropriate training is essential to maintaining a safe working environment. Staffing considerations should include:

- Maintain safe staffing levels to ensure the appropriate care and supervision of consumers at all times. High-risk situations, such as initial assessments, should be conducted on a team basis.
- Rostering needs to reflect appropriate staff mix, taking into account skills and experience, knowledge of systems and acuity of consumers, that is, level of disturbance.
- Difficult or dangerous consumers should have shared case management. Clinical care providers should have access to regular supervision to diminish individual's stress and burnout.
- Responsibility for the care needs and risk management of difficult to manage consumers should be removed from individual responsibility to a team management approach.
- Trained multidisciplinary emergency response/back-up teams should be available on all shifts.
- All new employees, including temporary staff such as nursing students and casual or bank staff, should have some basic training in both psychiatric care and aggression management. They should be provided with induction regarding the policies and procedures of the workplace and work practices that reduce the risk of occupational assault and they should not care for the most 'at risk' consumers.
- Management should not knowingly direct staff to enter an unsafe situation.
- Staff should not knowingly and unnecessarily enter an unsafe situation.
- Students should be given appropriate placements and be provided with adequate clinical and professional supervision.

6.4 Training-specific considerations

Research has identified a reduction in serious assault incidents where staff are trained in taking appropriate preventative measures.[9] Research has also shown that appropriate assessment, management and treatment of individuals prone to violence will reduce the incidence of aggressive acts.[10]

Organisations have a responsibility to have a framework that clearly outlines the policies, expectations and considerations in responding to occupational assault. Training is an essential component of this.

A comprehensive plan of response needs to address the environment in which services are delivered, how the service is delivered and how unpredictable matters are responded to.

9 Preventing Violence in the Healthcare Setting, Kathleen Brewer-Smyth, Nursing Spectrum-career Fitness OnLine.

10 Developing a Clinical Violence Prevention and Intervention Plan for Psychiatric Mental Healthcare Settings, Michael J. Sclafani, Journal of Healthcare and Quality, March/April 2000

Training in the prevention and management of violence and aggression should be provided to all staff. Training, however, should not be seen in isolation or as a panacea. Providing only personal training puts the onus of response solely on the individual and has been shown to be ineffective when not part of a comprehensive risk management approach.

Staff need to be made aware of situations commonly associated with aggression, such as particular diagnostic groups, past history of assaultive behaviour, substance use, age, the interventions being undertaken and the legal status of the consumer. Training of staff needs to focus on identifying factors that indicate increasing agitation and excitement and responding in a proactive way.

All staff should be trained to respond to potentially violent and aggressive situations.

Further guidance on training is shown on the next page.

Training to manage occupational violence risks

The key components of any training provided should be as follows:

- The policies and procedures of the workplace.
- Legal issues and legislative framework.
- Predicting, preventing and managing aggression and potentially assaultive situations.
- System of emergency response processes.
- Post-incident processes, including access to support systems.
- Induction systems for all staff, including permanent casuals, part-time staff and students, on commencement of work and regularly thereafter.
- Competency-based skills for all staff for the roles undertaken by them.
- Local practice issues that have an impact on response, such as access to support from others, sufficient staff available to respond to an incident, availability of emergency services and acceptable response times.
- Management personnel at all levels should be trained in the emergency response.
- Training should be compulsory for all staff and be provided in paid time to ensure attendance.

The above section outlines the key components that should be applied in any training provided to staff. A more comprehensive guideline to training is outlined in Appendix A.

6.5 Clinical response and considerations

Framework for controlling occupational violence in mental health services

Many incidents and potential incidents can be well managed through sound, proactive clinical processes and systems. Risk management through assessment and intervention is one of the best predictors of the potential for violence to staff. Considerations should include:

- Clinical indications for potential increased risk of violence as identified through clinical assessment, such as threatening behaviour, past history of assault, substance use, inadequate compliance with medication and treatment, organic syndromes, paranoid psychosis and others.
- Carers and significant others have a role to play in identifying and managing risk.
- Clinical interventions need to identify, predict and appropriately treat consumers who are aggressive or violent. This needs to occur at initial contact or referral and at regular intervals thereafter, or if the risk factors change.
- Systems of reviewing incidents need to consider legal accountability for violent actions and respond within a legal framework.
- Applying a clinical focus to any response ensures that the interventions used are those that have the most positive outcome for the individual consumer and carers as well as the staff member.
- When a patient is transferred to another clinical area current risks and risk management strategies should be shared with the new staff.

6.6 Security personnel/police

Trained security personnel should be employed and available as additional back-up/support wherever appropriate, for example, where a high level of risk relating to acutely disturbed consumers has been identified. Use of security personnel should be carefully considered and managed to avoid situations where their presence may escalate a situation.

Protocols for working with police should be established. Good liaison and working relationships with local police are important in achieving timely and effective responses.

Further guidance on clinical practice and security is shown on the next page.

Interventions in clinical practice for managing violence

- **Assessment of risk**: (already mentioned in the risk assessment section) risk assessment is a key method in clinical practice.
- **Environmental and organisational interventions**: (already mentioned in the risk control section) these interventions can contribute to minimising violence.
- **Observation**: a core nursing skill that helps build a therapeutic relationship with the client and is closely integrated with ongoing risk management.
- **Psychosocial strategies**: calming and de-escalation strategies are important interventions requiring an understanding of the whole violent incident cycle including symptoms of mental illness and its management.
- **Physical methods, including breakaway techniques and restraint methods**: may be required but must be used with the safety of all involved as the paramount consideration and in accordance with the provisions of the *Mental Health Act 1986* in relation to the use of restraint.
- **Psychopharmacological methods**: where required, these need to consider reactions to medication and any emergency situations that may arise.
- **Seclusion**: used as a last resort when other methods have failed and requires continual monitoring and dialogue with the client. The use of seclusion is regulated by the Mental Health Act.

Interventions in clinical practice for managing violence

- Is there an alarm and lighting control panel to alert co-workers of a violent incident and its location?
- If so, is the control panel monitored?
- Are personal alarms or panic buttons available?
- Where does the alarm or panic call go and whom does it alert?
- How is the problem area identified?
- Have motion sensors been installed at all entrances and exits?
- Is there a system in place to regularly check and report working order of alarm equipment?
- Are security guards or buddy systems available at your location?
- Are you trained, experienced and alert to warning signs?

7 Specific strategies for different situations

The steps and guidance outline needs to be modified to account for the range of mental health service settings and situations. Several examples follow.

7.1 Students

Students should:

- be given appropriate placements
- not be placed in potentially unsafe situations
- have clinical support and debriefing daily
- be provided with adequate clinical and professional supervision.

7.2 Working in the community

Staff working in the community should be provided with appropriate systems and resources to eliminate or minimise the risk of occupational assault. Such systems and resources include access to consumer alert information, provision of personal protective equipment, such as personal distress alarms (where practicable), mobile phones and, where appropriate, police. Pairing systems should occur where a potential risk has been identified.

Guidelines to be developed for community mental health workers should include:

- access to database information to assist in risk assessment of consumers in given situations
- risk identification associated with the consumer or the environment for the clinician
- high-risk consumers and initial community assessments to have two appropriately skilled and experienced staff assigned and a team approach to hazard management
- system for monitoring staff whereabouts at all times, including a response system should staff fail to return or call in as planned
- working in isolation
- provision of 4WD/AWD vehicles and satellite phones for rural community practitioners, where appropriate
- rights and responsibilities when working from other sites, such as consumers' or carers' homes, police cells or public areas.

Further guidelines on home visiting is shown on the next page.

Sample
Risk control measures for home visiting

Administrative controls[11]

Administrative controls decrease the likelihood of workplace violence by adjusting the way work is performed.

Develop case management plans that provide consistent approaches to the care of consumers, with strategies for preventing incidents of violence involving:

- patients/clients with medical/psychiatric conditions that put them at risk of committing acts of violence
- drug and alcohol-related environment
- disruptive non-clients.

Identify environmental hazards such as:

- isolation
- high crime rate in the area
- distant parking
- poor access for vehicles in remote areas and need for 4WD/AWD vehicles
- poor lighting
- limited visibility.

Implement violence prevention procedures such as:

- route sheets to identify patient/client locations and appointment times, including a copy to a designated check-in person
- a requirement that a designated check-in person be called after each visit, each identified risks visit, or each visit with a new, unknown patient
- a patient/client pre-screening procedure with safety checklists to determine risks before visiting patients/clients
- protocols with police about managing situations where clients have access to weapons
- pre-visit phone calls to identify hazards – check for environmental safety (lights, secured pets, best route into home) and patient/client status (emotional state, cognitive state, sobriety, attitude to visitor)
- specific forms designed to document the basis for refusal of service to a patient
- team visits or escorted visits for evening, night or high-risk visits, such as initial assessment of clients
- safe hours for visits - explore options for delivery of service during off-hours, such as the use of hospital emergency service or visits from the patient's own physician
- arrange to meet patient with better support than at home (for example, hospital, community health centre).

Ensure adequate lighting by:

- providing serviceable and compact flashlights
- making first visits in daylight only, wherever possible
- making visits to high crime areas in daylight only.

Provide personal controls such as:

- personal alarm
- mobile phone/satellite phone
- pagers
- ensure coverage is reliable with communication devices.

11 Adapted from: Preventing violence in health care: five steps to an effective program Workers' Compensation Board of British Columbia, 2000.

8 Post-incident management

8.1 Effective post-incident management strategies

Workplace violence and aggression, whether as a single event or as a result of long and continuous exposure, has a profound effect on mental health workers' physical and psychological health. This has significant implications for employers in the cost of sick leave, medical treatment, compensation, staff replacement and staff retention. Effective post-incident management can minimise the trauma and should incorporate the following strategies:

- All incidents of aggression and violence, both verbal and physical, should be reported to line managers and OH&S committees. As part of the quality assurance improvement program, monitoring of incidents should occur with openly posted results.
- Feedback and progress reports should be provided to staff.
- Staff health care clinics/services, where provided, should be notified of all incidents and offer assertive follow-up, support and assistance to victims of workplace assault.
- Staff health after an event should be monitored and the staff member made aware of emerging symptoms of stress.
- Debriefing services and teams should be made available as soon as practicable following any traumatic event, including single employee incidents.
- Debriefing services and counselling services must be provided by the employer and be easily accessible to all staff.
- Peer support teams that provide immediate support 24 hours a day should be established.
- A trained professional should provide support to staff.
- The right of a staff member to decline from participating in debriefing or counselling should be respected.
- A record should be kept of persons declining debriefing and/or counselling services.

Effective post-incident management includes adequate post-incident support each time an incident occurs. This process validates the staff member's experience, raises awareness for all staff, identifies those who will need further or ongoing support and begins the recovery process.

Employers should provide all reasonable assistance to staff for a timely supported return to work or timely receipt of compensation entitlements following an assault incident.

As part of the process, it is important that staff, in their professional capacity, are able to inform consumers when their behaviours are unacceptable.

8.2 Components of a post-incident management plan

All workplaces are expected to develop policies and procedures that consider the following components as part of basic post-incident management plan:

- demobilisation
- defusing
- debriefing
- identifying staff who will require longer term support
- maintaining records and data base
- evaluation process
- awareness of:
  - employee support services
  - self-care techniques
  - post traumatic stress and sequelae.

Policies and procedures should be established for reporting and evaluating incidents. When threats or incidents are reported it is critical that appropriate follow-up and communication take place. Liaison with policy should be established so that criminal acts will be handled appropriately.

8.3 Incident reporting

Employers should:

- encourage a culture that actively supports an open reporting process, including written incident reports, and strongly discourages a culture of acceptance of violence that diminishes staff concerns
- establish effective incident reporting systems, which include procedures for investigation, evaluation and review of systems/procedures and feedback to staff
- analyse incidents using a no blame approach to learn from the incident and to develop processes to mitigate against future risks
- look at events leading up to the incident, near misses not acted upon, what protocols were not followed, inconsistencies in the care of the client, information not shared
- maintain records of incidents, analyse and identify trends, and respond with appropriate interventions and feedback to staff
- support staff in reporting incidents of assault to police, laying charges and pursuing prosecutions.

Further guidance on incident reporting is shown on the next page.

Barriers to better reporting

Research has shown under-reporting is common in health care settings.

The reasons include:

- lack of available guidelines or operational policy, or lack of knowledge about such guidelines and policies
- lack of staff confidence/training
- no (or inadequate) incident recording form
- time and effort required to complete the incident recording form
- a perception that violence is 'part of the job' and therefore insufficiently unusual to report
- concern that violent incidents represent professional failure
- based on previous experience, lack of confidence that corrective action will be taken
- fear of litigation.

Incident report forms should:

- record hard factual information (for example, who was involved, when and where the incident occurred, whether a weapon was used, what injuries were sustained)
- describe how the incident occurred and what the outcome was
- allow staff to make suggestions or comments to management
- be concise and easily understandable
- provide for mandatory feedback to staff involved.

8.4 Maintaining a database

The collection, collation and investigation of data via OH&S committees are critical and should occur at both the individual workplace and organisational levels.

This data allows for the identification of local trends, which can inform changes required in matters such as building design and work practices. It can also identify consumers who have been violent and the possible triggers for staff to be alerted. This informs clinical decision making for those consumers and service planning.

On a broader level, the collation and reporting of data such as patterns of occupational violence and aggression, where they occur, demographic and diagnostic characteristics of consumers and the effectiveness of the response that was undertaken needs to be shared and reviewed so that research into occupational violence and aggression can continue.

This sharing of information may also highlight areas of best practice and responses and training that may be in place. It can also identify trends in occupational violence and aggression, the precipitants to the change, and potential responses on a statewide basis.

9 References and further information

Occupational Health and Safety Act 1985 (Victorian) and amendments.

Mental Health Act 1986 and amendments.

Crimes Act 1958 (Victorian) and amendments.

Workplace Relationship Act 1996 (Commonwealth) and amendments.

WorkSafe *Guidance note on the prevention and management of bullying and violence in the workplace.*

ANF (Vic Branch) *Zero tolerance (occupational violence and aggression) policy and interim guidelines and industry resource package.*

HACSU, *Occupational assault: a health hazard or just part of the job?*

Human Services Victoria, *Occupational Assault Reduction Policy 2001.*

Victorian Health Industry Occupational Health and Safety and WorkCover Advisory Committee, *Guidelines for the prevention and management of occupational aggression and violence in the Victorian health industry,* November 1995.

Department of Human Services, *Resource guide for critical incident stress and debriefing in Human Services agencies*, 1998.

Standards Australia, *Security for health care facilities*, AS4485.1&2 – 1997.

Standards Australia, *Risk management*, AS/NZ4360 – 1999.

Workers' Compensation Board of British Columbia, *Preventing violence in health care: five steps to an effective program* 2000.

United Kingdom Central Council of Nursing, Midwifery and Health Visiting, *The recognition, prevention and therapeutic management of violence in mental health care*, prepared by the Health Services Research Department, Institute of Psychiatry, London.

Victorian Institute of Forensic Mental Health, *M4 (management of aggression, management of the patient, management of the staff, and management of the environment) training package.*

10 Appendix A: Training guidelines

Principles of training

Training should:

- be practical and relevant to the workplace
- be flexible enough to allow modification to address particular issues within a workplace, to include direct and non-direct care staff
- be available in a way that facilitates regular updates
- emphasise both proactive and reactive responses
- address physical and psychological protective measures, such as follow-up after a critical incident and care of self
- ensure all temporary, casual and agency staff are trained to a competent level before being employed in mental health service
- consider local factors that have an impact on the type of response available to a consumer and staff member to support them
- comply with the criteria as outlined in these training guidelines.

Considerations

- Clinicians need to feel that training can assist them in everyday practice.
- Training should be competency-based.
- Training should incorporate the key components listed below and should be provided to all staff. Additional suitable modules should be provided according to whether staff participate in direct or indirect care (See section – 'Required length of training').
- Training providers should be appropriately accredited.

The following model identifies that the continuum of training should be based on the likely exposure to occupational violence and aggression and the key competencies for training that would be required to respond.

Key competencies of occupational violence and aggression response training

Organisations should be able to access existing programs and locally developed programs, provided it is demonstrated that they meet the key competencies for training, including:

- understanding what is meant by occupational violence
- understanding the precipitants and triggers of occupational violence
- understanding the legal boundaries, such as duty of care and reasonable force and employer and employee responsibility under the OH&S Act
- understanding policies and protocols of the workplace
- recognising conflict and situations of risk
- communication skills, sources and barriers
- awareness of professional responsibilities in relation to the law
- awareness of environment and its impact
- knowledge of self (own strengths and weaknesses, triggers)
- ability to undertake physical response to occupational violence
- effective avoidance and deflection techniques
- effective secure and escort techniques
- knowledge of reporting systems and their rationale
- awareness and use of personal protection devices and communication devices
- understanding the importance of risk assessment and reduction
- awareness and use of proactive risk assessment and related tools
- awareness and implication of 'the culture of silence/acceptance'.

Outcomes for individual staff member

- Safer working conditions.
- Improved confidence of staff member.
- Knowledge of expected participating role in a team response.
- Improved ability to identify escalating situations and respond in a preventative way.

Outcomes for organisation

- A reduction in the incidents of occupational assault and cost to the organisation.
- More accurate reporting of incidents of occupational assault, which improves analysis of trends and can positively affect preventative programs.
- Staff satisfaction and reduction in staff turnover.
- Compliance with OH&S legislative requirements in relation to staff education and training.

Outcomes for consumers

- Safer environment.
- Appropriate 'best practice' response.

Structure of training

Training should be targeted at the needs of target groups. Attendance at training must be recorded.

All staff need a common grounding in aggression prevention theory, breakaway and escape training, and the policies and protocols of the workplace.

Direct care staff need more specific training to meet the situations they deal with. Aggression prevention theory, breakaway/escape, restraint and safe consumer escort training are minimum requirements.

The length and delivery format will vary according to the mental health service setting and staff involved. Some training will be most effective with a short initial course (such as 1–2 days) followed up by refresher training held each year. Other situations may suit a longer initial training period (say, 3-5 days) with the option of less frequent refresher courses each year.

11 Appendix B: Typical training session outline

Session 3

Crisis communication skills

Explanations for the occurrence of violence, the physical manifestation of aggression and anger, have centred on patient characteristics and interpersonal factors in interactions between patients and staff.

De-escalation model of managing aggression has an important part to play in the therapeutic management of violent individuals. It is argued that physical intervention can be reduced to a minimum by using verbal and non-verbal interventions. Prevention is always preferable to intervention. It has been found that psychiatric health care workers often under-rate their negotiating skills. The average worker successfully negotiates upwards of 20–30 times per day but often concentrates on the 1–2 per cent of occasions that do not appear to have a satisfactory outcome. Failure to resolve a situation does not indicate fault or inadequacy on the part of the staff member.

Learning objectives

1. To provide participants with a theoretical overview of effective communication skills and to explore factors that facilitate or inhibit effective communication.
2. To provide participants with guidelines for de-escalating a potentially aggressive situation.

Session outline

- **Introduction** – discuss content of session using overhead. Look at why we need effective communication with patients and what the consequences are of poor communication.
- **Factors that facilitate communication** – use the whiteboard to discuss factors that enhance or inhibit communication.
  - Enhance – content (use of descriptive words) behaviour (body language and voice)
  - Inhibit – content and behaviour.
- **Brainstorm** – using whiteboard look at 'what works when communicating with a distressed person?'
- **Communication skills** – role play with participants. Divide into groups of three. Present two different role plays to choose from. Two participants do the role play and one critiques the role play.
- **Process role play**
  - What was it like as a patient, what worked and what didn't work?
  - What was it like as a staff member, how did you manage the situation?
  - How did you feel about it?
  - What did you learn from this?
- **Communicating and negotiating skills** – use overhead to look at the theoretical component of negotiation skills.

(Extract from M4 Training Course, Victorian Institute of Forensic Mental Health)