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Submission:

Canberra Health Services - Occupational Violence Policy and Procedure

Submitted by email to:
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This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from Canberra Health Services (CHS).

The Network is a consumer-led peak organisation representing the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

A consumer e-Forum was held, and additional feedback was sought via email in relation to the Canberra Health Services – Occupational Violence Policy and Procedure documents. Written and verbal feedback was received from several consumers. This submission incorporates both the written feedback and verbal feedback received.

General comments

The Network welcomes this opportunity to contribute to the CHS Occupational Violence (OV) Policy and Procedure documents. The OV Procedure document should ideally be written in plain language and should include illustrations such as flow-charts etc.

We have previously provided consumer feedback on both the OV Policy and Procedure documents in 2019. Some of the issues raised in this submission were covered in 2019 and continue to concern consumers.

Consumers noted that the language in the two documents did not always reflect that of the *Mental Health Act 2015* (ACT) (the Act) and recommend that the document be re-edited with this in mind. For instance, when referring to support persons, the word used in the OV Procedure (pp. 6, 14, 23) should include 'nominated person' as provided for under the Act. In addition, there is no mention of *My Rights, My Decisions* (Advance Agreements, Advance Consent Directions and Nominated Persons) which could be used to determine strategies to de-escalate OV scenarios.

The Scope is different between the two documents. Notably, patients are included in the list of people the OV Procedure covers whereas patients are absent from the OV Policy scope. This is a very important difference influencing the feedback included in this document. Consumers argue that given the Procedure includes patients then the policy should as well, requiring a rewrite of the Policy to ensure consumers are included overtly.

OV is workplace violence, and so both the OV Policy and OV Procedure should include staff against staff violence. If this isn't covered in these two documents, then the Occupational Violence Policy and Procedure that does cover staff against staff OV needs to be clearly identified.

Additionally, the two OV documents include references to both patients and consumers and they are used interchangeably. If they are seen as the same, then one or the other should be chosen and used consistently to avoid confusion. If they are seen as different, then they should be defined in both the OV Policy and OV Procedure. This document refers to patients and consumers respectively as used in the two documents for ease of understanding, except in relation to consumer feedback where we always use the term 'consumers'.

In addition, the lack of consumer equity and equality in a situation of OV was raised. Consumers advised that the focus should be on a consumers' human rights and safety as too often a consumer tries to obtain help but instead endures a negative experience. The identification of patients as the aggressors in all examples of incidents illustrates this (p.17).

Canberra Health Services – Occupational Violence Policy

<u>Recommendation 1: Scope</u>

As identified earlier, the Scope (p. 1) of the OV Policy is different from the Scope of the OV Procedure. The OV Procedure includes OV from consumers towards workers. Consumers noted this and recommended that if patients are to be included in the OV Procedure, they need to be included in the OV Policy.

<u>Recommendation 2: Language in line with legislation</u>

The language used in the OV Policy is not in line with the *Mental Health Act 2015* (ACT) (the Act). The term 'visitor' used throughout the document is only used in the Act when referring to the role of the 'official visitor'. Consumers recommend that 'visitor' be defined, and that the list of persons identified in the Act that provide

support to the consumer should also be listed where 'visitor' is used, including a person's nominated person and/or carer.

Recommendation 2: Trauma Informed Care

There is no indication that the principles of Trauma Informed Care influenced the development of the OV Policy.

Recommendation 2: Safewards

The OV Policy does not include any reference to Safewards (except within the references). Consumers noted that Safewards is included in the OV Procedure as being implemented in two units, one of which is the Adult Mental Health Unit. As it is being implemented, there should be mention of it in the OV Policy as one of the mechanisms available to reduce OV.

Recommendation 3

Consumers recommend the following two changes to the Evaluation chapter (p.3):

1. The evaluation should determine if there has been an increase/decrease in the prevalence of OV incidents and at what level they were resolved.
2. Relevant stakeholders should be advised of OV incidents. There currently appears to be no consumer feedback loop that provides a consumer voice into the evaluation of the OV Policy. This should be included given consumers' actions are at the heart of the OV Policy.

Recommendation 4: General Edits

Consumers noted that the readability of the OV Policy was poor, and the use of plain language and inclusion of diagrams and pictures would improve this issue.

On p4, consumers noted that there is no definition of acronym 'HSR', and that nominated person should be included where the OV Policy considers identified patient supports.

Canberra Health Services – Occupational Violence Procedure

Recommendation 1: Training requirements

There are various levels of training outlined in the Procedure, from basic training for all staff to OV training for Security Officers. Consumers were concerned that the baseline training for all staff was conducted through eLearning and that there appears to be no mandatory refresher course for some staff. Concern included the

need for refresher training in the case of changes in OV legislation, as well as the need to practice these techniques, especially de-escalation techniques which would ideally be done face to face given it is difficult to gauge body and other non-verbal language via eLearning.

Recommendation 2: Including My Rights My Decisions training

Consumers recommend the inclusion of *My Rights, My Decisions* (MRMD) training and documentation as part of the OV Procedure. Referring to a consumer's MRMD documentation at a point of crisis can assist with de-escalation as the consumer may understand that their rights and wishes are being considered as part of their treatment. In addition, suggesting a consumer's nominated person could visit and be included in any discussion regarding OV could help to de-escalate the problem.

Recommendation 3: Inclusion of De-escalation Table/Process

Consumers commented positively regarding the de-escalation options that are outlined in Section 3, part 3 (pp. 6-8) and elsewhere throughout the OV Procedure. They did, however, suggest that a table of de-escalation techniques indicating options and when they could be put into practice (similarly in Attachment 4) would add value to the procedure.

Recommendation 4: Recording and Communicating OV Risks

The Recording and Communication of OV Risks (p. 8) in such a way that it sits at the front of the consumer's patient record could lead to the inappropriate labelling of a patient as 'difficult'. Consumers expressed concerns that labelling could be based on subjective information that is passed from word of mouth from one staff member to another, and on instances when a person was acutely unwell. Consumers suggested that the OV Risk could sit on a patients record but should be re-evaluated at each admission.

Recommendation 4: Weapons Management

Consumers noted that three mental health units are not on the list (p. 16) that the weapons management plan could also apply to. They are: Unit 12B, the Older Persons Mental Health Unit and the Adolescent Mental Health Unit (once opened).

Recommendation 5: Inclusion of Code Grey

Consumers recommend the inclusion of Code Grey (p. 15), as used in Safewards, instead of heading directly to Code Black. Code Grey is a less-stigmatising and more patient focussed level that looks at de-escalation in a non-threatening manner.

Consumers noted that Safewards is used in the Adult Mental Health Unit, and recommend its inclusion in other mental health units as it champions the patient and assists with de-escalation.

Recommendation 6: Evaluation

There appears to be no identified pathway for a consumer to provide feedback into the evaluation process (pp. 23-24). Likewise, there appears to be no pathway for consumers to have a say regarding the OV incident anywhere in the OV Procedure. Inclusion of processes for both would add value to the procedure.

Recommendation 7: Number of Related Procedures

There is a large number of related procedures listed at the end of the document (pp. 24-25). Consumers expressed concern as to how staff would be able to access and learn them all. Perhaps including links to these documents to allow immediate reference could assist staff to be able to follow the procedures effectively in difficult circumstances.

Recommendation 8: Cultural and Linguistic Diversity

The Signs of Violent or Aggressive Behaviour table, Attachment 4 (p. 37) lists a patients cultural and linguistic diversity and physical and mental disability as things a "patient is affected by or has a previous history of". This identifies low English language skills, hearing disability and medical illness, including mental illness, as signs of violent and aggressive behaviour.

Instead of being seen as signs of violent and aggressive behaviour, consumers recommend that an individuals specific needs, such as medical requirements, Cultural and Linguistic Diversity supports and other history should be considered at admission and tools put in place to support the patient during their hospital stay. As one consumer said, "*if I had a hearing disability and someone kept shouting the same information at me that I couldn't understand, I would get irritable too*".

Recommendation 9: Communication by letter

The Written Warning Letter, Attachment 2 (p. 32) should be provided in relevant languages where possible. In addition, they need to be discussed with the consumer to ensure they understand everything that is written and what it means, with an interpreter if the person needs one and/or other supports such as their nominated person.

Recommendation 10: General editorial comments

As with the OV Policy, consumers noted that the readability of the OV Policy was poor, and the use of plain language and inclusion of diagrams and pictures would improve this issue.

The following edits are recommended:

- p5: first dot point, if using both ‘consumer’ and ‘patient’, need to include an either/or symbol between them, and provide definitions of both. The terms should not be used interchangeably as this would cause confusion;
- p5: second dot point, ‘consumer’ should be plural;
- p9: second line, second paragraph, remove the word ‘the’ as redundant;
- p10: under 5. Security response and systems, first dot point, delete ‘as per the’ as it is repeated;
- p23: Under the heading Outcome, dot point 2, the words ‘in the’ are repeated.

Conclusion

These recommendations are based on consumer feedback provided to enhance the policy and procedure documents.