MENTAL HEALTH SERVICE GUIDELINE COVER SHEET

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SUMMARY	Guideline for the timely and appropriate assessment and management of risk in mental health practice, including assessment and management of harm to self and others, in both inpatient and community mental health settings.

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Section 1 - Background

The assessment and clinical management of the clinical risks associated with the mental health of consumers is an integral part of mental health practice. It should be recognised that assessment and management of identified risks are integrated and interdependent functions of the same process.

Risks identified most often relate to the potential for causing harm to self or others, or being exposed to harm from others in various ways. These need to be considered broadly, including direct and indirect risks which also include risks relating to sexual safety, physical health, neglect and financial risks from care.

This guideline aims to support Mental Health Service (MHS) staff to perform optimal comprehensive risk assessment and management in clinical situations. It can be used alongside structured risk management assessment tools.

This document is not an exhaustive resource and should not replace clinical judgement and usual protocols for escalation in complex cases following the usual clinical governance guidelines.

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Section 2 - Principles

South Eastern Sydney Local Health District (SESLHD) MHS upholds the rights of the consumer to be treated with respect and dignity at all times. The service understands that tolerance of some risk is essential for all people to lead a dignified life.

The service integrates risk management practices to identify, evaluate, monitor, manage and communicate clinical risks, in order to provide a safe and inclusive environment for consumers, staff, and others within the service.

This document is not an exhaustive resource and should not replace clinical judgement and usual protocols for escalation in complex cases following the usual clinical governance guidelines.

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Section 3 - Definitions

Definition:

Throughout this document, the terms patient, client and consumer may be used interchangeably to acknowledge the varying preferences of people who give and receive services in the SESLHD MHS.

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Section 4 - Responsibilities

SESLHD Mental Health Service is responsible for:

- Circulating this guideline to the Directors/Managers of each site/service.

Service Directors/Site Managers are responsible for:

- Ensuring that this guideline is circulated, promoted, implemented and governed locally.

All clinical staff members are responsible for:

- Ensuring that appropriate clinical risk assessment and management practices are implemented to provide safe quality care.

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Section 5 – Components

5.1 Guiding principles

- Awareness and formal assessment of risks is required to be performed as an ongoing process throughout an episode of care. The assessment to occur at triage, initial mental health assessment, admission to inpatient and community services, The assessment is likely to be required at multiple times during an episode of care (admitted or community based) including but not limited to clinical review points, a change in clinical status, prior to leave, upon return and prior to transfer of care and/or discharge.
- The risk assessment process is individually specific and requires application of clinical judgement. (Reference: Royal College of Psychiatrists UK).
- A risk assessment needs to be conducted with both short-term dynamic and longitudinal static factors in mind, and must be subject to frequent and regular review.
    - ***Static (or enduring)*** factors are not subject to change, and include factors such as history, age, gender and ethnicity. These factors are important to consider for people with mental health conditions, however static factors alone are incomplete predictors of risk.
    - ***Dynamic (or changeable)*** risk factors can alter over brief periods, and are dependent on individual circumstances. Dynamic factors include, but are not limited to, current presenting symptoms, substance use or recent psychosocial stressors.
- Corroborative information needs to be sought from anyone who may have useful and relevant information, and/or who can play a role in the risk management plan. This includes:
    - Families and Carers.
    - Other service providers e.g. GPs, private psychiatrists, community and support services.
    - Other stakeholders, where relevant such as the Police and Ambulance services.
- Formulated risks must be clearly documented in the clinical file with a clear plan describing in detail how these risks will be managed.
- The use of stratified risk assessments in isolation (where risk is categorised as “low”, “medium” or “high”) should be avoided as there is now good evidence that this form of risk assessment cannot adequately predict risk outcomes, and may adversely impact consumer care. When a categorical risk rating cannot be avoided, it must be accompanied by a qualitative rationale, management plan and any implications for consumer care.
- All relevant stakeholders must be aware of the plan including their own roles as described in the plan.
- All plans should include a timeframe for review which should be at a minimum according to the standard clinical review frequency for the care setting.

5.2 Risk categories

Include but are not limited to:

- Suicide and Self Harm

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- Potential for Aggression/Violence
- Sexual Safety
- Severe Self Neglect
- Exploitation
- Reputation
- Absconding
- Damage to Property
- Physical Health

5.3 Clinical risk assessment

- Risk assessment is the gathering of information and analysis of the potential for harmful behaviours. It identifies specific risk factors for an individual in the context in which they occur, within a process of linking past information to current circumstances.
- A comprehensive mental health assessment must take place, using the relevant sections within the electronic Medical Record (eMR). This initial assessment will inform the start of the risk assessment process.
- The NSW Ministry of Health has mandated the use of risk assessment tools contained in the current clinical modules:
    - IB2020_021 – Mental Health Community and Outcome Measures Collections: Reporting Requirements from 1 October 2020
    - PD2022_043 - Clinical Care of People who may be Suicidal
    - PD2021_039 - Mental Health Clinical Documentation
- If additional risk assessment tools are used, they should be supplementary to the tools contained in the clinical modules. The mandated Mental Health Current Assessment module in eMR provides a section for risk assessment to be documented, and is to be used as the minimum standard for risk assessment documentation. Refer to SESLHDGL/074 - Clinical Documentation in Mental Health under *Section 5.2.1 Assessment of Risk* and SESLHD eMR Clinical Documentation Handbook: Mental Health Services.
- A formalised risk assessment is an essential element of information collection and analysis to formulate and document a risk management plan. This risk assessment requires continuous, ongoing review to ensure timely action or modification of the consumer management plan.

When assessing and management of risk(s), all known factors should be considered. These may include:

Consumer

- Mental state examination
- Context/situation(s) eg consider Women in the Perinatal Period
- Past history
- Culture/language eg consider ATSI, refugee
- Level of engagement
- Intoxication/withdrawal states.

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Carers
- The service should seek to work collaboratively with consumers and their carers in obtaining and providing information or offering support to carers.

Staff
- Experience and training
- Access to and use of information
- Workforce mix.

Environment
- Physical layout (for inpatient units)
- Objects or items presenting potential risks
- Emotional stimulation
- Current consumer cohort mix/risk.

Systems
- Communication and coordination
- Service structures and procedures
- Access to medical records/documentation
- Access to clinical management options available within the health service.

Initial assessment
The initial clinical assessment should include a comprehensive biopsychosocial assessment, which incorporates the risk assessment and includes:
- Collecting history related to the psychological, physical, intellectual, emotional, social and spiritual wellbeing of the consumer
- Identifying situations or factors associated with the increased probability of risk behaviours which may result in adverse events
- Identifying protective factors.

History
- Accurate history taking is an important component in the subsequent risk assessment. Relevant information should be obtained from health records and referral letters as well as asking consumers, carers, other family members and friends. Information should also be sought from other service providers e.g. GP, private Psychiatrist, community/other support services.
- Sometimes it may not be possible to obtain sufficient information to conduct a comprehensive risk assessment, in which case this should be recorded, and arrangements made to seek relevant information at a later stage. In the absence of comprehensive information, clinicians should take a more cautious approach and manage the consumer as if they have an elevated risk profile until sufficient information is obtained.
- History taking should include:
    - Recent/historical suicide attempts or current suicidality
    - A history of self-neglect
    - A forensic history

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  - A history of aggression and/or violence
  - Preoccupation with violent acts or ideology
  - A history of vulnerability/exploitation
  - Poor compliance with treatment, or disengagement with mental health services
  - Precipitants (such as drug and alcohol use) and any changes in mental state or behaviour that may have occurred prior to current presentation and/or relapse
  - Psychosocial stress including recent severe stress, events related to loss or the threat of loss
  - Recent discontinuation of medication
  - Recent threatening behaviour including threats of violence/verbal threats
  - A history of intimidation/stalking
  - Parental mental health (including pregnancy/recent childbirth)
  - Needs of children
  - Domestic violence
  - Trauma – current or historical
  - Physical harm or neglect of minors under the care of the client (see SAFE START in References section below).
- Changeability of risk status, especially in the immediate period, should be assessed and high changeability should be identified. While risk status by nature is dynamic and requires reassessment, identification of high changeability will guide a safe interval between risk assessments. Where possible, foreseeable changes (specific events that, if they occur, will lead to a deterioration in risk status) should be documented, along with a contingency plan to mitigate the risk.

Continuing assessment

- As part of the continuing assessment process, risk factors should be identified, particularly where there may be factors or situations likely to increase the risk of an adverse event.
- Reassessment of risk should occur as per PD2022_043 - Clinical Care of People who may be Suicidal. "An assessment of risk must be conducted at key points of clinical care: **admission, review, discharge, and when there is a change in clinical picture**.
- Risk reassessment for consumers in an **inpatient unit**: the SESLHD MHS requires the reassessment of risk to occur at least twice per day in an inpatient unit (more frequently if the consumer's acuity requires it) and should be conducted by the Primary Nurse (or Nurse In-Charge of Shift in their absence) in consultation with all available members of the consumer's multidisciplinary team. Each reassessment of risk is to be documented within the consumer's eMR.
- Risk reassessment for consumers cared for within the **community setting:** the SESLHD MHS requires the reassessment of risk to occur with each clinical contact. Clinical contact should be increased where the consumer's acuity requires it. Each reassessment of risk is to be documented within the consumer's eMR.
- The level of clinical risk is dynamic, changeable and may be influenced by circumstances which can alter over brief periods. Therefore, the assessment of risk should be subject to frequent review in multidisciplinary team discussions." As per this document, corroborative information should be sought and considered in formulation of the risk level. (see Appendix A for a comprehensive list of risk factors and management strategies).

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- Risk assessment for minors in the care of a client is to be assessed with the aid of the NSW Government Mandatory Reporter Guide (MRG).

5.4 Communication and documentation

- Effective communication of risk information is fundamental to the assessment and management process.
- It is essential that the multidisciplinary team is informed of the consumers' history and risk factors. All relevant information should be recorded in the consumer's eMR, made immediately known to all staff involved in the management plan and care, and then fully discussed at the next available multidisciplinary meeting.
- 'ALERTS' and 'Identified Risks' are to be recorded clearly in relevant sections of the consumer's eMR or hard copy records if a paper file is used.
- All staff are equally responsible for maintaining knowledge/awareness of changes to documented risks and management plans contained within the medical record (see SESLHDGL/074 - Clinical Documentation in Mental Health under *Section 7.2.1 Assessment of Risk* for more information).
- It is the responsibility of staff to ensure that they disclose information to other agencies, according to related policies and procedures as appropriate and on a 'need to know' basis, so other agencies can understand what the risks are for consumers, and how these can best be managed.

5.5 Clinical risk management

- Risk management is a process of using knowledge about the consumer to inform clinical judgements, interventions and organisational procedures that minimise risk (see Appendix A for management strategies).
- Risk management requires a documented statement, a collaborative management plan with both consumer and/or carer input, and an allocation of individual responsibilities for actioning the plan.
- The documentation should name all relevant people (including consumers and carers, following assessment of carer capacity) involved in the management plan, their responsibilities, supportive roles and a review date for the assessment and management plan.
- Consumer and carer participation should be maximised early and throughout care, especially in monitoring for early warning signs and to minimise risk related behaviours.
- Excessive restrictive and controlling practices may contribute to an increase in risk behaviours, therefore a balance between least restrictive and most restrictive care should be sought.
- Section 79 of the NSW Firearms Act 1996 provides that "*if a health professional is of the opinion that a person to whom the health professional has been providing professional services may pose a threat to public safety (or a threat to the person's own safety) if in possession of a firearm, the health professional may inform the police of that opinion. A health professional that makes this notification cannot be held liable for breaching any duty of privacy or confidentiality*". If a mental health consumer is known to have access to a firearm and is considered at risk, a clinician

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is required to complete a NSW Police Force – Firearms Registry 'Disclosure of Information by Health Professionals' Form (see Appendix B).

- Considerations should be given to management strategies when there is risk of harm to a pregnant woman or her infant (see SAFE START in References section below).
- Any change in risk that requires modification to the subsequent management plan is to be discussed with, and endorsed by, the Consultant Psychiatrist.

5.6 Multidisciplinary team working

- All staff members are expected to engage in teamwork and multidisciplinary decision making processes. Systems should be in place to ensure that this occurs.
- The following should be in place to enhance multidisciplinary team working:
    - Documentation of who is involved in providing care and treatment for each consumer, and the specific clinician who is responsible for each part of the management plan
    - Full multidisciplinary team clinical review meetings occurring regularly (weekly for acute inpatient units), as per SESLHDPR/642 - Clinical Review in Mental Health.
    - An escalation pathway for when members of the multidisciplinary team disagree on risk assessment/management eg clinical escalation to the site Clinical Director or referral to the complex care review committee as per SESLHDBR/029 - Referral to the Mental Health Service (MHS) Complex Care Review Committee.

5.7 Consumer and family/carer involvement

- It is essential to the management of risk that consumers and their family/carers are actively involved in decisions relating to all aspects of their care, within the limits of 'patient confidentiality'.

5.8 Staff learning and development

An integral component of risk assessment/management practices is staff skill enhancement and development in order to achieve excellent quality of service delivery and safe practice.

5.9 Incident reporting (IMS+)

All staff should receive training in, and ensure that they are aware of, how to correctly report incidents using the IMS+ framework. This framework ensures incident recording, investigation, implementation of agreed action plans and trend analysis in accordance with NSW Health Policy Directive PD2020_047 - Incident Management.

5.10 Clinical audit and monitoring

- Clinical audit is a component of the Quality Improvement process and is an essential tool in managing risk and raising the quality of care through:
    - Assessing the quality of practice against established standards
    - Highlighting areas of concern regarding the quality of consumer care
    - Improving practice through informed feedback.

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Section 6 – Documentation & References

Documentation

- See Appendix A and Appendix B.
- NSW Government Mandatory Reporter Guide (MRG)

References

NSW Ministry of Health
- PD2020_004 - Seclusion and Restraint in NSW Health Settings
- PD2022_043 - Clinical Care of People who may be Suicidal
- PD2017_043 - Violence Prevention and Management Training Framework for NSW Health Organisations
- PD2019_045 - Discharge Planning and Transfer of Care for Consumers of NSW Mental Health Services
- PD2024_008 - Service Specification for Non-Emergency Transport Providers
- PD2006_084 - Domestic Violence – Identifying and Responding
- PD2020_047 - Incident Management
- PD2013_038 - Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services
- GL2013_012 - Sexual Safety of Mental Health Consumers Guidelines
- GL2010_004 - SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants
- PD2010_016 - SAFE START Strategic Policy
- PD2010_017 - Maternal & Child Health Primary Health Care Policy
- IB2020_021 - Mental Health Community and Outcome Measures Collections: Reporting Requirements from 1 October 2020
- PD2021_039 - Mental Health Clinical Documentation
- Mental Health National Outcomes and Casemix Collection: Technical specifications of State and Territory reporting requirements.2011 version 2.11

NSW Acts
- NSW Mental Health Act (2007)
- NSW Health Administration Act 1982
- NSW Children and Young Persons (Care and Protection) Act 1998
- NSW Firearms Act 1996

SESLHD
- SESLHDPR/484 - Patient Leave from Acute Inpatient Units - Mental Health Service
- SESLHDPR/615 - Engagement and Observation in Mental Health Inpatient Units
- SESLHDPR/293 - Consumer Sexual Safety in Mental Health Settings
- SESLHDPR/318 - Firearms and/or Prohibited Weapons: Notification to Police of Consumers Suspected of Having Access to a Firearm and/or Prohibited Weapon
- SESLHDGL/027 - Clinical Supervision of Nurses and Midwives
- SESLHDGL/016 - Allied Health Clinical Supervision

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- SESLHDGL/074 - Clinical Documentation in Mental Health
- SESLHDPR/595 - Emergency Sedation Procedure - Acute Inpatient Mental Health Units
- SESLHDPR/642 - Clinical Review in Mental Health
- SESLHD eMR Clinical Documentation Handbook: Mental Health Services

National

- National Safety and Quality Health Service (NSQHS) Second Edition Standards 1.3, 1.15, 5.7, 8.8
- National Standards for Mental Health Services 2010: Standard 2. Safety (2.11)

Others

- 'Violence and aggression: short-term management in mental health, health and community setting'. National Institute for Clinical Excellence (NICE) Clinical Guideline NG10, National Health Service, London 2015

Version and Approval History

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July 2019	6.0	DDCC endorsed change from Policy to Guideline Content review by authors Reformatted to Guideline
August 2019	6.0	Further review by authors Circulated to the SESLHD MHS DDCC and Clinical Directors for review and feedback
August 2019	6.1	Incorporates feedback from SESLHD MHS DDCC
October 2019	6.1	Endorsed by SESLHD MHS DDCC Endorsed by SESLHD MHS Clinical Council
December 2019	6.2	Incorporates feedback from Draft for Comment - document title amended to include "Mental Health"
December 2019	6.2	Reviewed by Executive Services prior to progression to SESLHD Clinical and Quality Council
March 2020	6.2	Endorsed at SESLHD Clinical and Quality Council. Published by Executive Services
October 2020	6.3	Updated to comply with new NSW Health PD2020_004 Seclusion and Restraint in NSW Health Settings Endorsed by SESLHD MHS Document Development & Control Committee Endorsed by SESLHD MHS Clinical Council
May 2021	6.3	Approved by Executive Sponsor.
January 2022	v7.0	Routine review commenced. Reviewed by authors and the Project Manager Zero Suicides in Care. Minor feedback received and incorporated.
February 2022	v7.1	Circulated to the Document Development and Control Committee for review/feedback.
March 2022	v7.2	Further refinement of text, including rewording of sections to remove references to "high risk", "medium risk", "moderate risk", "low risk" as per feedback. Endorsed Document Development and Control Committee Approved by Executive Sponsor

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February 2024	v7.3.1	Reviewed by working group
April 2024	v7.3.2	Reviewed by DDCC.
May 2024	v7.3	Changes identified in Appendix A. Recirculated to DDCC Endorsed DDCC Endorsed Clinical Council
12 September 2024	7.3	Cover page amended to Mental Health Service Guideline. Document published.

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Appendix A: Risk Factors

Factors to be considered in the management of:

- Suicide
- Assaultive Potential
- Sexual Safety
- Severe Self Neglect
- Exploitation
- Reputation
- Absconding
- Damage to property.

Suicide:

Risk factors

- Adverse experiences & trauma in childhood
- Alcohol & other drug problems
- Key transitions and disconnection
- Psychosocial stressors and adverse life events
- Discrimination, stigma and inequity
- Grief and loss
- Loneliness and isolation
- Feelings of hopelessness and emotional suffering
- Exposure to suicide and availability of methods
- Priority population - Aboriginal and Torres Strait Islander, culturally diverse and linguistically diverse, LGBTQIA+, youth, men, homelessness, veteran and defence force personnel.

Significant Life Events

- Psychotic illness
- Recent loss (i.e. death, relationship, job, financial losses)
- History of depression
- Anniversary of the death of a loved one
- Times when loneliness and loss may be accentuated e.g. Christmas, Easter, birthdays
- Withdrawal from friends, co-workers and family or disruption to established relationship/s.
- Foreseeable changes identified by the consumer that will increase their level of suicidal distress and engagement in suicidal / self-harming behaviour
- Psychosocial stressors

Management Strategies

When a person is identified as experiencing suicidal thinking, distress or self-harming behaviour, mental health clinicians must undertake a suicide prevention risk formulation. The risk formulation is person centred and evidenced based which is relevant to the person's suicide risk and safety planning.

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Suicide Prevention Risk Formulation:

A person-centered suicide prevention formulation provides the best way to ensure that the most effective care can be tailored to a person's needs the process:

- Synthesises information collected in the Comprehensive MH Ax- Static and Dynamic risk factors, to understand the context behind the persons suicidality.
- Determine the person's internal coping strategies
- Identify external resources to assist in navigating and managing suicidal distress
- Identify foreseeable changes that would increase the level of suicidal distress and engagement in suicidal or self-harming behaviour

Safety Planning

A Safety Plan is a detailed, written plan developed by the person and clinician that outlines concrete steps an individual and their supports can take to recognise and respond to a suicidal crisis.

- Develop a mental health safety plan, that supports and guides a person following experiencing thoughts of suicide, suicidal or distress or suicidal crisis
    - Aims to help avoid a state of intense suicidal crisis-through future planning
    - Guides clinical formulation, transitions of care and handover processes.
    - Includes personal, social and professional supports
    - Include lethal means counselling and contingency planning
- Document the mental health safety plan and risk formulation using the consumers words using the eMR Dynamic Document: MH Safety Plan Adult, MH Safety Plan Child and Adolescent or MH Safety Plan Carer.
- Family and carers should be involved in risk formulation and safety planning, particularly when creating contingency plans.

Assaultive Potential:

Risk Factors

- History not known
- The person has physically attacked others in the recent past
- Level of orientation to time, place, person
- Specific delusional content e.g. harm to others, persecutory delusions, ideas of reference
- Command hallucinations
- Poor impulse control
- Resistance to admission procedures
- Intoxication and/or withdrawal
- Agitation
- Elevated mood/grandiosity
- Recent forensic history of assault
- Fearful and/or suspicious affect exhibited
- History of aggression towards others.

Considerations should be given to the following **management strategies** when there is risk of assaultive potential:

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- Assign appropriate Engagement and Observation Level Category as determined by risk assessment in consultation with the Nurse in Charge and Treating Psychiatrist or medical delegate
- Staff are to ensure they are not alone with a consumer who has been identified as having assaultive potential.
- Location of bed as close to the staff office as possible, if appropriate
- Allocation of a single room where possible; consideration of the mix of consumers in dormitory if single room not available
- Careful monitoring of consumer interactions in communal areas such as lounge, dining rooms and garden. It may be appropriate for a particular consumer to have meals at a separate time to the majority of the other consumers or in a different place
- Differing levels of trust and rapport between staff and consumer is an important consideration when allocating staff to consumers identified as having assaultive potential each shift
- Comprehensive communication, handover and documentation in consumer file of any problems or concerns experienced to all staff
- Consider staffing levels and the need for additional staffing e.g. security
- Consider psycho-education and behavioural strategies e.g. diversion
- Development and documentation of clear management plan by treating team on admission
- Consistent application of management plan developed by treating team and documentation of the consumer's responses to its application
- Educate consumer about the importance of medication
- Appropriate use of regular medication with regular medical review. AVOID excessive PRN medication. Explore education with the consumer around medications.
- Appropriate leave arrangements, in accordance with risk category
- Aim to complete a My Wellness plan

Sexual Safety:

There are three key policy documents governing Sexual Safety:

1. PD2013_038 - Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services
2. GL2013_012 - Sexual Safety of Mental Health Consumers
3. SESLHDPR/293 - Consumer Sexual Safety in Mental Health Settings

Severe Self Neglect:

'Self neglect' is characterised as intentional or unintentional behaviour by a person that threatens their own health and safety. 'Self neglect' usually means that a person refuses or fails to provide themselves with the necessities of life.

Risk Factors

- History of severe and enduring mental illness with associated severe self neglect
- Homelessness
- Untreated or unattended health problems
- Malnutrition/dehydration
- Hazardous or unsafe living conditions (e.g. unsafe wiring)
- Chronic alcohol/drug dependence

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- Disengagement from community mental health services/non-compliance with medication
- Neglect of dependent others
- Isolation/lack of social support from family/friends
- Budgeting (e.g. not paying rent, running up debts)
- Unsanitary or unclean living conditions
- Inappropriate and/or inadequate clothing, lack of medical aids (e.g. eye glasses, hearing aid)
- Unkempt or untidy dress.

Consideration should be given to the following **management strategies** when there is evidence of self neglect:

- A comprehensive, interdisciplinary, psychosocial assessment and needs analysis
- Development and documentation of clear management plan by treating team on admission
- Consistent application of management plan developed by treating team and documentation of the consumer’s responses to its application
- Educate consumer about the importance of self-care, necessities of life and medication
- Referral to appropriate community mental health/other support services for follow up and management, when no other social support available
- Appropriate leave arrangements, in accordance with risk category
- Allocation of relevant allied health professionals.

Exploitation:

Exploitation is exerting undue influence or forcing a vulnerable adult to perform services for the benefit of others. This may be in the form of **sexual, financial, physical, social** or **emotional** exploitation.

Risk Factors

- History of being exploited
- Heightened sexual activity
- Sexual disinhibition (seductive gestures, stance, gaze, body movements, sexual talk, touching others in sexual manner, revealing clothing)
- Not responsive to contracting with staff not to engage in sexual activities
- Marked disorganisation associated with psychotic or affective illness
- Unexplained sudden transfer of assets to someone in or outside the family
- Requesting peers to carry out banking transactions
- Having large amounts of money on person, with reluctance to place it in secure safe
- Lack of accounting for way finances have been spent.

Consideration should be given to the following **management strategies** when there is a risk of exploitation by others:

- Assign appropriate Observation Level Category as determined by risk assessment in consultation with the Nurse in Charge and Treating Psychiatrist or medical delegate
- Ensure safe environment by removing access to situations where the consumer’s vulnerability may be exploited
- Allocate bed close to staff office, or nurse elsewhere, with other strategies in place

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- Encourage the safe keeping of valuables, banking materials and monies
- The enforced removal of assets, banking materials and monies, within the appropriate legislative process, in situations where the existence of, or potential for, exploitation is considered to be damaging and ongoing
- If relevant, attempt to contract with consumer not to engage in sexual activities; such a contract must be reviewed with the consumer within a defined time-frame e.g. shift by shift.
- Review use and sharing of electronic devices.

Reputation:

Risk Factors

- Inappropriate, reckless behaviours in the context of psychotic or affective illness (e.g. sexual disinhibition, heightened sexual activity, internally/externally directed aggression)
- Marked disorganisation associated with psychotic or affective illness
- Minimal insight to the consequences of risk behaviours
- Intellectual/cognitive impairment.

Considerations should be given to the following **management strategies** when there is risk of damage to reputation:

- Assign appropriate Observation Level Category as determined by risk assessment in consultation with the Nurse in Charge and Treating Psychiatrist or medical delegate
- Ensure safe environment by removing access to situations where the consumer's reputation may be damaged
- Allocate bed close to staff office, or nurse elsewhere, with other strategies in place
- Encourage involvement in the unit program with a view to providing education, purpose and socially acceptable behaviours.

Absconding:

Risk Factors

- Consumers assessed as being at risk of suicide/self harm
- Previous history of absconding from inpatient care
- Minimal insight associated with psychotic or affective illness
- Alcohol/illicit drug dependence use
- Admission to hospital via the police, courts or prison
- Consumers intolerant of authority.

Considerations should be given to the following **management strategies** when there is risk of absconding:

- Decision made about which unit to admit to and manage a consumer in, in accordance with risk category
- Assign appropriate Observation Level Category as determined by risk assessment in consultation with the Nurse in Charge and Treating Psychiatrist or medical delegate
- Appropriate leave arrangements, in accordance with risk category
- Encourage involvement in the unit program with a view to providing education, purpose and a meaningful plan for each day
- Assess for, and assist with, alcohol/illicit drug withdrawal symptoms
- Education of family regarding their responsibilities during leave.

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Damage Risk:

Risk Factors

- Previous history of deliberate or accidental fire setting
- Known smoker with marked disorganisation associated with psychotic/affective illness
- Known smoker with alcohol/drug intoxication
- Known history of damage to property.

Considerations should be given to the following **management strategies** when there is risk of fire setting:

- Assign appropriate Observation Level Category as determined by risk assessment in consultation with the Nurse in Charge and Treating Psychiatrist or medical delegate
- Ensure safe environment by removing access to situations where the consumer may be considered a risk (e.g. unsupervised cooking, remove rubbish bin in bed area)
- Allocate bed close to staff office
- Remove lighters/matches
- Encourage compliance with designated smoking area.

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Appendix B: The NSW Police Force – Firearms Registry

'Disclosure of Information by Health Professionals' Form is accessible here.

www.police.nsw.gov.au

ABN 43 408 613 180

NSW POLICE FORCE - FIREARMS REGISTRY

Disclosure of Information by Health Professionals

Section 79 of the *Firearms Act 1996 and* Section 38 of the *Weapons Prohibition Act 1998*

Section 79 of the *Firearms Act 1996* and Section 38 of the *Weapons Prohibition Act 1998* protect disclosures of information to the NSW Commissioner of Police by health professionals where they are of the opinion that a person they are treating may pose a risk to public safety or to the person's own safety if in possession of a firearm or prohibited weapon. Of particular interest are high risk mental health patients known to have access to firearms.

Section 79 of the *Firearms Act 1996* and Section 38 of the *Weapons Prohibition Act 1998* provide protection from civil or criminal liability, that may otherwise arise including a breach of confidentiality, when disclosing information to the Commissioner of Police.

A health professional, is defined in Section 79 of the *Firearms Act 1996* and for the purposes of Section 38 of the *Weapons Prohibition Act 1998*, as any of the following persons: a medical practitioner, psychologist, nurse , social worker or professional counsellor.

PROCESS TO FOLLOW

1. Complete the form and Fax to 02 66708558 and mark 'Attention - Team Leader Licensing', AND
2. Fax this form to the police station nearest the residential address of the patient. If you are unsure of the nearest police station, ring the Police Assistance Line on 131444.

PATIENT INFORMATION

LAST NAME		FIRST NAME	
DATE OF BIRTH		TELEPHONE	
HOME ADDRESS			

Where is the patient currently located? eg inpatient, Accident and Emergency, at residential address etc.

If in hospital, anticipated date of discharge. To ensure safety issues can be addressed, please give at least 6 hours notice to Police. DATE OF DISCHARGE

ADDRESS WHERE PATIENT WILL BE DISCHARGED (if different from residential address).

Describe the circumstances that lead you to believe that the person may pose a threat if in possession of a firearm/prohibited weapon. Include relevant conversation, observations, circumstances, effect of medical condition or treatment on person's capacity etc.

Does the person have access to their own firearms/prohibited weapons?	☐ YES	☐ NO	☐ UNKNOWN
Does the person have access to other firearms/prohibited weapons?	☐ YES	☐ NO	☐ UNKNOWN

If 'YES' indicate below the address where the firearms/prohibited weapons are located? For example, with friends, neighbours, spouse or other relative.

HEALTH PROVIDER INFORMATION

☐ Medical Practitioner ☐ Psychologist ☐ Reg/Enrolled Nurse ☐ Social Worker ☐ Counsellor

NAME		CONTACT NUMBER	
SIGNATURE		DATE	

Reporting Location (eg hospital, mental health hotline, private clinic, facility etc)

ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE

Vers 3.3 *August 2024*

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