SESLHD 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.

SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

Clinical Risk Assessment and Management – Mental Health

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.

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.

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.

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.

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. This includes at triage, initial mental health assessment, admission to inpatient and community services, at clinical review points, with a change in clinical status, prior to leave 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.
- Stratified risk assessments (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 should 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
- Potential for Aggression/Violence
- Sexual Safety
- Severe Self Neglect

- Exploitation
- Reputation
- Absconding
- Damage to Property
- Physical Health
- Women in the Perinatal Period
- Those with carer responsibilities

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
  - PD2016_007 - Clinical Care of People who may be Suicidal
  - PD2010_018 - 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 risk, all known factors should be considered. These may include:

Consumer

- Behaviours, cognition and affect
- Context/situation(s)
- Past history
- Culture/language
- Level of positive engagement
- Intoxication/withdrawal states.

Carers
- Provision of enough information and support to participate in the assessment process, care provision and supervision of an acutely ill person before, during and after an episode of care.
- Seeking consent to speak with relatives/carers and offering the opportunity to be seen without the consumer being present, so they can speak freely.

Staff
- Experience and training – both personal and professional
- 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 suicide attempts or ideation (gauge extent, planning)
  - A history of self-neglect

- A forensic history
- 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
- 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
- History of trauma
- 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 the NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004) and PD2016_007 - 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).
- 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' – identified risk(s) 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 5.2.1 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 translating knowledge about the consumer into 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 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 i.e. clinical escalation to the Clinical Director in consultation with the relevant manager including Clinical Operations Manager, Community MH Service Manager or Consultant Psychiatrist for Community Mental Health.

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'. In order to achieve this, the following information should be made available:
  - Unit/Community Team information (e.g. philosophy, visiting times, contact details and therapeutic activities).
  - An individual care plan which is collaborative, transparent and clearly understood by the consumer.
  - Written and verbal information on medication, effects and related side effects.
  - Information related to consent, the NSW Mental Health Act (2007) and rights of appeal.
  - Multidisciplinary team meetings related to consumers' care.
  - Availability of 'patient centred' organisations (e.g. advocacy, Official Visitors).
  - Complaints procedure.

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. See SESLHDBR/011 - Mental Health Mandatory Training for Clinical Staff for details of training requirements.

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 Ministry of Health Policy 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.
- Where possible, the following activities should be avoided. They should only be used as a last resort, where there is a risk to the safety of staff and/or consumers. If used, they must be accurately documented, audited and reviewed to ensure good clinical practice. These activities should include:
  - Restraint
  - Seclusion and other restrictive practices
  - Rapid tranquillisation and high dose medication.

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
- PD2016_007 - 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
- Health Share GL2020_005 Mental Health Transfers – Non Emergency Patient Transport
- 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
- PD2010_018 - Mental Health Clinical Documentation
- NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004)
- NSW Health education resource 'Improving Consumer Outcomes in Mental Health: Clinical Documentation and Outcome Measures' (2011)

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 - Notification to Police of Patients Suspected of Having Access to a

Firearm and/or Prohibited Weapon
- SESLHDGL/027 - Clinical Supervision of Nurses Midwives
- SESLHDGL/016 - Clinical Supervision Guidelines - Allied Health
- SESLHDBR/011 - Mental Health Mandatory Training for Clinical Staff
- 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 Standard 1: Clinical Governance Standard (1.3, 1.15)
- National Safety and Quality Health Service (NSQHS) Second Edition Standard 5: Comprehensive Care Standard (5.7)
- National Safety and Quality Health Service (NSQHS) Second Edition Standard 8: Recognising and Responding to Acute Deterioration Standard (8.8)
- National Standards for Mental Health Services 2010: Standard 2. Safety (2.11)
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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

Revision and Approval History

Date	Revision no:	Author and approval
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.

Date	Revision no:	Author and approval
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

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.

While there are consistencies in management strategies for the above, each risk element is described separately for specificity purposes.

Suicide:

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.

The following two tables are from the NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004).

Table 1: Examples of demographic, group and personal risk factors for dying from suicide

Demographic factors	Groups at higher risk	Current personal risk factors
■ Male ■ Between 25-44 years of age ■ Older people ■ Living in rural area ■ Members of minority groups (eg Aboriginal and Torres Strait Islander people) ■ People with sexual identity conflicts ■ Immigrants, refugees, asylum seekers ■ Homelessness	■ Previous history of attempts or self-harm ■ History of a mental illness, particularly depression, schizophrenia, other psychotic illness, personality disorder ■ History of sexual or physical abuse or neglect ■ First presentations of mental illness ■ Victims of domestic violence ■ Alcohol and other substance abuse; co-morbidity ■ Older immigrants from non-English speaking backgrounds ■ Immigrants from northern and eastern Europe ■ Refugee victims of torture and trauma ■ Serious physical illness or disability ■ People in prison or police custody	■ 'At risk mental status', for example, hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes ■ Recent interpersonal crisis, especially rejection, humiliation ■ Recent major loss or trauma or anniversary ■ Alcohol intoxication ■ Drug withdrawal state ■ Chronic pain or illness ■ Financial difficulties, unemployment ■ Impending legal prosecution ■ Family breakdown, child custody issues ■ Lack of social support network ■ Unwillingness to accept help ■ Cultural or religious conflicts ■ Difficulty accessing help due to language barriers, lack of information or support, or negative experiences with mental health services prior to immigration

In line with current practice, the risk ratings in the table below should be interpreted as:

- **High Risk = Immediate Action Required**
- **Medium Risk = Action Required**
- **Low Risk = Document and Continue to Monitor**

Suicide Risk Assessment Guide

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High Risk	Medium Risk	Low Risk
'At risk' Mental State – depressed – psychotic – hopelessness, despair – guilt, shame, anger, agitation – impulsivity	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts – intentionality – lethality – access to means – previous suicide attempt/s	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
Substance disorder – current misuse of alcohol and other drugs	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History – family, carers – medical records – other service providers/sources	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) – expressed communication – availability of supports – willingness / capacity of support person/s – safety of person & others	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective practice – level & quality of engagement – changeability of risk level – assessment confidence in risk level.	Low assessment confidence or high changeability or no rapport, poor engagement.		– High assessment confidence / low changeability; – Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable? **Highly Changeable** **Yes** ☐ **No** ☐

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/or conflicting information. **Low Assessment Confidence** **Yes** ☐ **No** ☐

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:

- 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
- Appropriate leave arrangements, in accordance with risk category
- Complete a safety 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

Sexual Safety Policy Training is Mandatory for all mental health members. Ensure your HETI training is update to date.

The two tables below are taken from NSW Ministry of Health Guideline - GL2013_012 Sexual Safety of Mental Health Consumers

4.1.1 Assessing vulnerability

All consumers are vulnerable by the nature of their illness and/or the experience of being hospitalised. Being female in particular increases the consumer's vulnerability to being sexually assaulted or harassed, as is being under the age of 18 years. Other factors that increase the risk for a consumer of being sexually assaulted include:

- Having a past history of being sexually assaulted
- Being a young female experiencing their first admission
- Being heavily medicated
- Being intoxicated and/or having a comorbid drug and alcohol condition
- Having an intellectual disability
- Being Aboriginal or Torres Strait Islander
- Being a refugee/torture and trauma survivor
- Experiencing a psychosis
- Being a victim/survivor of domestic violence
- Sexual disinhibition
- Having a cognitive impairment e.g. delirium

4.1.2 Taking an appropriate sexual assault and harassment history

Taking a consumer's history of *perpetrating* sexual assault is also vitally important to assess the risk that they may continue to offend while involved with the mental health service, separate them from consumers that have been identified as vulnerable and to ensure they receive appropriate support to recognise their behaviour as inappropriate.

Risk factors for offending include:

- Having a history of sexually offending behaviour
- Having a history of domestic violence offending
- Violent and threatening behaviours
- Intimidating behaviours including sexual harassment
- Sexually disinhibitive behaviours
- Acute drug intoxication e.g. methamphetamines

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
- 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
- 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.

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.

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.

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 3.1 *May 2018*