<table>
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<th>NAME OF DOCUMENT</th>
<th>Clinical Risk Assessment and Management</th>
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<td>TYPE OF DOCUMENT</td>
<td>Policy</td>
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<tr>
<td>DOCUMENT NUMBER</td>
<td>SESLHDPD/291</td>
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<tr>
<td>DATE OF PUBLICATION</td>
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<tr>
<td>RISK RATING</td>
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| LEVEL OF EVIDENCE       | National Safety and Quality Health Service Standard: Standard 1 - Governance for Safety and Quality in Health Service Organisations  
                          | National Standards for Mental Health Services 2010 – 2.11 Safety  
                          | Safety notice: Assessment and management of risk of absconding from declared mental health inpatient units SN:004/16 |
| REVIEW DATE             | December 2018                           |
| FORMER REFERENCE(S)     | Clinical Risk Assessment and Management Policy 2006/05 Version 4 |
| EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR | David Pearce  
                          | Director of Operations  
                          | SESLHD Mental Health Service |
| AUTHOR                  | Dr Murray Wright  
                          | Director  
                          | SESLHD Mental Health Service |
| POSITION RESPONSIBLE FOR THE DOCUMENT | Director  
                          | SESLHD Mental Health Service |
| KEY TERMS               | Assessment, risk, admission, leave, discharge, suicide, self-harm, violence, neglect, exploitation, absconding, unauthorised absence, absent without leave (AWOL) |
| SUMMARY                 | This policy provides advice regarding the timely and appropriate assessment of risk and management of risk in mental health practice, including assessment and management of harm to self and others, in inpatient and community mental health settings. |

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY  
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1. POLICY STATEMENT

The assessment and clinical management of the risk of a mental health patient causing harm to self or others, or being exposed to harm from others, is an integral part of mental health practice. Risk assessment and risk management are two entirely integrated functions of the same process.

This policy is consistent with the requirements of NSW Ministry of Health Policy Directives including, but not limited to PD2016 _007 - Clinical Care of People who May be Suicidal, PD2012 _035 - Aggression, Seclusion and Restraint in Mental Health Facilities in NSW, PD2017 _043 - Violence Prevention and Management Training Framework for NSW Health Organisations, PD2006 _084 - Domestic Violence – Identifying and Responding, SESLHDPR/293 Consumer Sexual Safety in Mental Health Settings, and Safety Notice: Assessment Management of Risk of Absconding from Declared Mental Health Inpatient Units SN004/16.

2. AIMS

This policy aims to assist Mental Health Service (MHS) staff to perform optimal comprehensive risk assessment and management in clinical situations.

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

3. TARGET AUDIENCE

This policy is for all SESLHD MHS staff involved in the assessment and management of clinical risk.

4. RESPONSIBILITIES

4.1 The District MHS Office is responsible for circulating this policy to the Directors-Managers of each site/service.

4.2 Site/Service Directors-Managers are responsible for ensuring that this policy is circulated, promoted, implemented and governed locally.

4.3 All clinical staff members are responsible for ensuring that appropriate clinical risk assessment and management practices are implemented to provide safe quality care.

5. DEFINITIONS

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.
6. POLICY COMPONENTS

6.1 Guiding Principles
- All patients require a risk assessment to be performed, at initial mental health assessment, admission, throughout the inpatient episode of care, prior to leave and prior to transfer of care and/or discharge and/or with a change in clinical status.
- Where possible, a corroborative interview with carers should also be conducted.
- Risk is dynamic and may depend on circumstances that can alter over brief periods. Therefore, risk assessment needs to be conducted with both a short-term and a longitudinal time frame and must be subject to frequent and regular review.
- Among people with mental health conditions, factors such as age, gender and ethnicity are, in general, unreliable predictors of risk. Therefore, the process is individually specific (Reference: Royal College of Psychiatrists UK).
- Corroborative information needs to be sought and clearly documented not only from family/carers, but also from other service providers e.g. GPs, Private Psychiatrists, community and support services.
- People who present a risk to others are also likely to be vulnerable to self harm, self neglect or exploitation.
- Identified risks should be documented after a comprehensive, collaborative assessment.
- Formulated risks require a documented management plan, including a timeframe for review.

6.2 Risk Categories
- Suicide and Self Harm
- Potential for Aggression/Violence
- Sexual Safety
- Severe Self Neglect
- Exploitation
- Reputation
- Absconding
- Fire
- Physical Health
- Women in the Perinatal Period

6.3 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 PD2006_041 - Mental Health Outcomes and Assessment Tools (MH-OAT) Data Collection Reporting Requirement 1 July 2006, PD2016_007 - Clinical Care of People who May be Suicidal, and
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 MH 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 SESLHD eMR Clinical Documentation Handbook: Mental Health Services.

- In the absence of additional SESLHD-approved standardised risk assessment tools, each site should continue to apply local guidelines, checklists and electronic tools to aid the risk assessment process.
- 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 patient management plan.

The context in which risks should be considered are:

**Patient**
- Behaviours, cognition and affect
- Context/situations
- Past history
- Culture/language
- 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 opportunity to be seen without the patient being present so they can speak freely.

**Staff**
- Experience – personal and professional
- Access to and use of information
- Workforce mix.

**Environment**
- Physical layout (for inpatient units)
- Potential risk objects
- Emotional stimulation
- Current consumer cohort mix/risk.

**Systems**
- Communication and coordination
- Service structures and procedures
- Access to medical records/documentation
- Access to management options available with the health service.
Initial assessment
The initial assessment should include a comprehensive biopsychosocial assessment, which encompasses far more than a risk assessment and includes:
- Collecting history related to the psychological, physical, intellectual, emotional, social and spiritual wellbeing of the patient
- 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 patients, 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 an accurate 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 allocate a high risk category 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
  - 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.
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 i.e. in inpatient units, at least twice daily for high risk, at least daily for medium risk and at least weekly for low risk patients. In the community setting, for high risk this should be within 24 hours, within one week for medium risk and within one month for low but current risk (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).

6.4 Communication and Documentation

- Effective communication of risk information is fundamental to the assessment and management process. Failure in communication can have serious consequences for patients, carers, clinicians and the general public.
- It is essential that the multidisciplinary team is informed of patients’ history and risk factors. All relevant information should be recorded in the medical record and in eMR and made immediately known to all staff involved in the management plan and care, 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 medical record, including eMR and hard copy records if a paper file exists.
- The decision to reduce the level of risk assigned to a patient must be authorised by the Consultant Psychiatrist (see SESLHDPD/615 - Engagement and Observation in Mental Health Inpatient Units) and a rationale for the change must be recorded in the medical record.
- All staff are equally responsible for maintaining knowledge/awareness of changes to documented risks and management plans contained within the medical record.
- 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 they can understand what the risks are for consumers and how these can best be managed.

6.5 Clinical Risk Management

- Risk management is a process of translating knowledge about the patient into clinical judgements, interventions and organisational procedures that minimise risk (see Appendix A for management strategies).
- Risk management requires a documented statement, management plan and an allocation of individual responsibilities for actioning the plan.
- The documentation should name all relevant people (including patients 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.
• Patient and carer participation should be encouraged early and throughout, 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 breach of privacy or confidentiality”. If a high risk consumer is known to have access to a firearm, staff members are 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).

6.6 Multidisciplinary Team Working

• Multidisciplinary assessment, a shared management plan and good interagency communication are important aspects of risk management. All staff 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:
  o A clear written philosophy, providing a shared ‘vision’ with clarity of roles and responsibilities, which is documented and clearly understood
  o Specific guidelines on who should be involved in providing care and treatment for each patient and which clinician is responsible for which part of the management plan
  o Full multidisciplinary team clinical review meetings occurring at least once each week
  o A clear procedure for when members of the multidisciplinary team disagree on risk assessment/management i.e. clinical escalation to the Chief Psychiatrist in consultation with the relevant manager including Clinical Operations Manager, Community MH Service Manager or Consultant Psychiatrist for Community Mental Health.

6.7 Patient and Family/Carer Involvement

• It is essential to the management of risk that patients 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:
  o Unit/Ward/Community Team information (e.g. philosophy, visiting times, contact details and therapeutic activities)
  o An individual care plan which is collaborative, transparent and clearly understood by the patient
o Written and verbal information on medication, effects and related side effects
o Information related to consent, the NSW Mental Health Act (2007) and rights of appeal
o Multidisciplinary team meetings related to patients’ care
o Availability of patient centred organisations (e.g. advocacy, Official Visitors)
  o Complaints procedure.

6.8 Patient Leave – Inpatient Units

- All leave arrangement should satisfy the content of the SESLHDPR/484 Patient Leave from Acute Inpatient Units - Mental Health Service, which includes specific criteria for granting leave, must be in place and include comprehensive reassessment of risk prior to granting leave and before leave is taken.
- The status of leave authorisation, for each episode of leave, must be counter-checked by two clinicians prior to the patient being released from an inpatient unit. These two clinicians should be the primary nurse allocated to the patient’s care and the shift coordinator. In the event that either the primary nurse or shift coordinator is unavailable, then the leave status must be counter checked by another senior clinician.
- Leave should be graduated, in the majority of cases, to minimise risk and allow progressive assessment of the patient’s capacity to manage leave (accompanied/unaccompanied, short/overnight or longer).
- Comprehensive information about patient leave is to be noted within the medical record and must include; risk status for harm to others, harm from others, harm to self, suicide, absconding, sexual safety, falls, physical health, changeability, care level, name of the Medical Officer approving leave, rationale for leave, details of service support, medication arrangements, name of person responsible for the patient while on leave, dates and times of leave commencement and conclusion.

6.9 Unauthorised Absence

- Unauthorised absence is when patients absent themselves from an inpatient setting and is defined as absent without leave (AWOL) or missing.
- In order to ensure a consistent approach to the reporting of incidents of patients being AWOL from mental health facilities, note the following:
  o The Nurse in Charge of Shift should use their professional judgement in relation to the late returning of a patient from authorised leave, and should discuss and agree to a response with the responsible clinician (or his/her delegate). If the patient or carer informs the ward of a reasonable delay to returning from leave this may not be viewed as being AWOL. However, a risk assessment of the patient’s situation should always be undertaken.
- All incidents of AWOL should be reported as an incident via the Incident Information Management System (IIMS) and categorised into:
  o Absconding Type 1 – Involuntary Patient (Mental Health Act 2007 (the Act)) who absconds from a Mental Health Inpatient Unit
  o Absconding Type 2 – Involuntary Patient who absconds whilst on accompanied leave
  o Absconding Type 3 – Involuntary Patient who fails to return from leave
Absconding Type 4 – Other (this may include absconding during transfer between units and other events not inclusive of the above categories)

- Ensure the absconding type is stated at the first words within the incident review section.
- All Absconding Type 1 and Type 2 must have a Reportable Incident Brief (RIB) completed and approved by senior mental health management. AWOL status must be determined with appropriate senior staff.
- All IIMS notifications and RIBs must include information regarding the risk status of the client and an appropriate Severity Assessment Code (SAC) according to this assessed risk.
- All SAC 1 and SAC 2 incidents of AWOL are to be reported to the SESLHD MHS Director and the Site Director/Site Executive via RIB.
- All SAC 1 incidents of AWOL and SAC 2 incidents (which may involve a NSW Police investigation/media/high clinical risk) should be reported to the NSW Ministry of Health.
- For all AWOL incidents involving an IIMS notification, a note should be made in the IIMS system when the patient has been located and returned to the Inpatient Unit, or a decision made to appropriately discharge the person. The notation should include an indication of the basis for the decision to discharge.
  Include additional:
  - Preventative messages
  - Contributing factors
  - Initial action taken
  - Results of incident report
  - Incident minimalising factors
  - Legal status.
- The incident should not be closed within the IIMS system until such time as the outcome of the unauthorised absence event is known.

6.10 Discharge and Transfer of Care Planning – Inpatient Units, Psychiatric Emergency Care Centres (PECCs) and Emergency Departments

- When discharging or transferring care of patients with complex needs who are assessed as being at some risk to themselves or others, there needs to be a process of communication and information sharing with Acute Care Team, community clinicians and other community agencies (see NSW Ministry of Health Policy - PD2016 056 Transfer of Care from Mental Health Inpatient Services).
- Specific management processes for ‘at risk’ patients can be found within the NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004) and the SESLHDPR/484 Patient Leave from Acute Inpatient Units – Mental Health Service.

6.11 Physical Environment – Inpatient Units and Emergency Departments

The physical environment has considerable impact on the safety of the environment for both staff and patients/consumers.

- Personal alarm systems must be carried by staff, such that when activated other staff are alerted to an emergency, particularly in environments which are large and which offer blind spots.
• Systems should be in place when staff escort patients on short and extended leave. Mobile phones and two-way radios are of particular value in such situations, and on occasions when a patient may have absconded. It is recommended that mobile phones be pre-programmed with the numbers of the ward/unit, facility reception and NSW Police.

• Any facility which is used by individuals for whom the service has responsibility should be the subject of an annual (minimum standard) safety and security review.

• It is recommended that environmental checks, at regular intervals throughout each day, be undertaken as part of an overarching risk management plan.

6.12 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.

6.13 Incident Reporting (IIMS)
All staff should receive training in, and ensure that they are aware of, how to correctly report incidents using the IIMS framework. This framework ensures incident recording, investigation, implementation of agreed action plans and trend analysis in accordance with NSW Ministry of Health Policy - PD2014_004 Incident Management Policy.

6.14 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:
  o Assessing the quality of practice against established standards
  o Highlighting areas of concern regarding the quality of patient care
  o Improving practice through informed feedback.

• High risk activities which are essential to practice should be accurately documented, audited and reviewed to ensure good clinical practice. These activities should include:
  o Restraint
  o Seclusion and other restrictive practices
  o Rapid tranquillisation and high dose medication.

7. DOCUMENTATION
• See APPENDIX A and APPENDIX B.
• NSW Government Mandatory Reporter Guide (MRG)

8. REFERENCES

NSW Ministry of Health
• NSW Ministry of Health Policy - PD2012_035 Aggression, Seclusion and Restraint in Mental Health Facilities in NSW
• NSW Ministry of Health Policy - PD2016_007 Clinical Care of People who May be Suicidal
• NSW Ministry of Health Policy - PD2017_043 Violence Prevention and
Management Training Framework for NSW Health Organisations

- NSW Ministry of Health Policy - PD2016_056 Transfer of Care from Mental Health Inpatient Services
- NSW Ministry of Health Policy - PD2005_139 Transport of People Who are Mentally Ill
- NSW Ministry of Health Policy - PD2006_084 Domestic Violence – Identifying and Responding
- NSW Ministry of Health Policy - PD2014_004 Incident Management Policy
- NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004)
- NSW Department of Health resource ‘Improving Consumer Outcomes in Mental Health: Clinical Documentation and Outcome Measures’ (2011)
- NSW Ministry of Health Policy - PD2013_038 Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services
- NSW Ministry of Health Guideline - GL2013_012 Sexual Safety of Mental Health Consumers
- NSW Ministry of Health Guideline - GL2010_004 SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants
- NSW Ministry of Health Policy - PD2010_016 SAFE START Strategic Policy
- NSW Ministry of Health Policy - PD2010_017 Maternal & Child Health Primary Health Care Policy
- NSW Ministry of Health Policy - PD2016_056 Transfer of Care from Mental Health Inpatient Services
- NSW Ministry of Health Policy - PD2006_041 Mental Health Outcomes and Assessment Tools (MH-OAT) Data Collection Reporting Requirement 1 July 2006
- NSW Ministry of Health Policy - PD2010_018 Mental Health Clinical Documentation

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 and Midwives
- SESLHDGL/016 Clinical Supervision Guidelines - Allied Health
- SESLHDBR/011 - Mental Health Mandatory Training for Clinical Staff
- SESLHDPR/595 Emergency Sedation Procedure - Acute Inpatient Mental Health Units
9. REVISION & APPROVAL HISTORY

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<td>March 2012</td>
<td>V4</td>
<td>Endorsed by SESLHD MHS Clinical Council.</td>
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<tr>
<td>January 2015</td>
<td>V5v1</td>
<td>Initial review undertaken by Angela Karooz, SESLHD MHS Clinical Nurse Manager and Victoria Civils-Wood, SESLHD MHS Policy and Document Development Officer.</td>
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<td>July-August 2015</td>
<td>V5v2</td>
<td>Clinical review led by TSH MHS CNC3, Kim Reid. Consultation with MHS Clinical Coordinators, Chief Psychiatrists and Clinical Operations Managers.</td>
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<td>September 2015</td>
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<tr>
<td>July 2017</td>
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<td>Consulted with Site Clinical Operation Managers. Reviewed and updated by District Clinical Nurse Manager. Endorsed by MHS DDDCC.</td>
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<td>September 2017</td>
<td>V5.5</td>
<td>Updated Section 6.9.2.2. and Section 6.9.2.3. Pending MHS Clinical Council endorsement.</td>
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<td>October 2017</td>
<td>V5.5</td>
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<tr>
<td>December 2017</td>
<td>V5.5</td>
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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
- Fire.

Whilst 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 two tables below are from the NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004).
<table>
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<tr>
<th>Demographic factors</th>
<th>Groups at higher risk</th>
<th>Current personal risk factors</th>
</tr>
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<tbody>
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<td>Male</td>
<td>Previous history of attempts or self-harm</td>
<td>'At risk mental status', for example, hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes</td>
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<tr>
<td>Between 25-44 years of age</td>
<td>History of a mental illness, particularly depression, schizophrenia, other psychotic illness, personality disorder</td>
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<tr>
<td>Older people</td>
<td>History of sexual or physical abuse or neglect</td>
<td>Recent interpersonal crisis, especially rejection, humiliation</td>
</tr>
<tr>
<td>Living in rural area</td>
<td>First presentations of mental illness</td>
<td>Recent major loss or trauma or anniversary</td>
</tr>
<tr>
<td>Members of minority groups (eg Aboriginal and Torres Strait Islander people)</td>
<td>Victims of domestic violence</td>
<td>Alcohol intoxication</td>
</tr>
<tr>
<td>People with sexual identity conflicts</td>
<td>Alcohol and other substance abuse: co-morbidity</td>
<td>Drug withdrawal state</td>
</tr>
<tr>
<td>Immigrants, refugees, asylum seekers</td>
<td>Older immigrants from non-English speaking backgrounds</td>
<td>Chronic pain or illness</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Immigrants from northern and eastern Europe</td>
<td>Financial difficulties, unemployment</td>
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<tr>
<td></td>
<td>Refugee victims of torture and trauma</td>
<td>Impending legal prosecution</td>
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<td></td>
<td>Serious physical illness or disability</td>
<td>Family breakdown, child custody issues</td>
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<td></td>
<td>People in prison or police custody</td>
<td>Lack of social support network</td>
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Suicide Risk Assessment Guide

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

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

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? 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 □
In The Event That a Suicide Occurs
Management guidelines in the event of a suicide are outlined in the SESLHD Mental Health Service Procedure: SESLHDPR/287 Contact with Families following the Death of a Client.

Assaultive Potential:

High Risk Factors
- History not known
- The person has 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.

Moderate Risk
The patient has a past history of aggressive or violent behaviour but is not currently assessed as a risk. It is considered, through thorough professional assessment by the interdisciplinary team, taking into account the factors noted for High Risk, that the patient exhibits adequate control in social situations to be considered of no current risk to others.

Low Risk
The patient has no known history of aggressive or violent behaviour and is not currently assessed as a risk.

Considerations should be given to the following management strategies when there is risk of assaultive potential:
- Assign appropriate Care Level category as determined by risk assessment in consultation with Nurse in Charge and Treating Psychiatrist or Medical delegate
- Staff are to ensure they are not alone with a patient assigned High Risk
- 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 patients in dormitory if single room not available
- Careful monitoring of patient interactions in communal areas such as lounge, dining rooms and garden; it may for example be appropriate for a particular patient to have meals at a separate time to the majority of the other patients or in a different place
- Differing levels of trust and rapport between staff and patient is an important consideration when allocating High risk patients to staff each shift
- Thorough communication, handover and documentation in patient 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 patient’s responses to its application
• Educate patient 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:

- NSW Ministry of Health Policy - PD2013_038 Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services
- NSW Ministry of Health Guideline - GL2013_012 Sexual Safety of Mental Health Consumers
- SESLHDPR/293 Consumer Sexual Safety in Mental Health Settings

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
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.

High 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.

Moderate Risk Factors

• 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
• Poor domestic skills (e.g. kitchen safety/cooking).

Low Risk

The patient has no known history of intentional or unintentional self neglect and is not currently assessed as a risk.

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 patient’s responses to its application
• Educate patient 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.

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.

High 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.

Moderate Risk
The patient has a past history of exploitation by others but is not currently assessed as a risk. It is considered, through thorough professional assessment by the interdisciplinary team, taking into account the factors noted for High Risk, that the patient exhibits adequate control in social situations to be considered of no current risk.

Low Risk
The patient has no known history of being exploited by others and is not currently assessed as a risk.

Consideration should be given to the following management strategies when there is a risk of exploitation by others:
• Assign appropriate Care Level Category as determined by risk assessment in consultation with Nurse in Charge and Treating Psychiatrist or medical delegate
• Ensure safe environment by removing access to situations where the patient’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 patient not to engage in sexual activities; such a contract must be reviewed with the patient within a defined time-frame e.g. shift by shift.
Reputation:

High Risk
- 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.

Moderate Risk
The patient has a past history of behaviours which have damaged their reputation but is not currently assessed as a risk. It is considered through thorough professional assessment by the interdisciplinary team, taking into account the factors noted for High Risk, that the patient exhibits adequate control in social situations to be considered of no current risk.

Low Risk
The patient has no known history of having damaged their reputation and is not currently assessed as a risk.

Considerations should be given to the following management strategies when there is risk of damage to reputation:
- Assign appropriate Care Level Category as determined by risk assessment in consultation with Nurse in Charge and Treating Psychiatrist or medical delegate
- Ensure safe environment by removing access to situations where the patient’s reputation may be damaged
- Allocate bed close to staff office or nurse elsewhere, with other strategies in place
- Encourage involvement in the ward program with a view to providing education, purpose and socially acceptable behaviours.

Absconding:

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

Moderate Risk
The patient has a past history of absconding from inpatient care, but is not currently assessed as a risk. It is considered through thorough professional assessment by the interdisciplinary team, taking into account the factors noted for High Risk, that the patient exhibits adequate control and insight, to be considered of no current risk.
Low Risk
The patient has no known history of absconding from inpatient care and is not currently assessed as a risk. Considerations should be given to the following **management strategies** when there is risk of absconding:

- Decision made about which ward to admit to and manage a patient in, in accordance with risk category
- Assign appropriate Care Level Category as determined by risk assessment in consultation with Nurse in Charge and Treating Psychiatrist or Medical delegate
- Appropriate leave arrangements, in accordance with risk category
- Encourage involvement in the ward 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.

Fire Risk:

High Risk:
- Previous history of deliberate or accidental fire setting
- Known smoker with marked disorganisation associated with psychotic/affective illness
- Known smoker with severe physical incapacity
- Known smoker with alcohol/drug intoxication
- Known smoker with known disregard for designated smoking areas.

Moderate Risk
The patient has a past history of deliberate or accidental fire setting, but is not currently assessed as a risk. It is considered, through thorough professional assessment by the interdisciplinary team, taking into account the factors noted for High Risk, that the patient exhibits adequate control and insight, to be considered of no current risk.

Low Risk
The patient has no known history of deliberate or accidental fire setting and is not currently assessed as a risk.

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

- Assign appropriate Care Level Category as determined by risk assessment in consultation with Nurse in Charge and Treating Psychiatrist or Medical delegate
- Ensure safe environment by removing access to situations where the patient 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.

NSW POLICE FORCE - FIREARMS REGISTRY

Disclosure of Information by Health Professionals
Section 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998

Section 79 of the Firearms Act 1996 & 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.

Sections 79 of the Firearms Act 1996 & 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 S79 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: 0266 708558 and mark 'Attention - Team Leader Licensing', ANO.
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

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
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<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>TELEPHONE</th>
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<table>
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<tr>
<th>HOME ADDRESS</th>
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Where is the patient currently located? e.g. 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.

<table>
<thead>
<tr>
<th>DATE OF DISCHARGE</th>
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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.

<table>
<thead>
<tr>
<th>DOES THE PERSON HAVE ACCESS TO THEIR OWN FIREARMS/PROHIBITED WEAPONS?</th>
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<tbody>
<tr>
<td>YES</td>
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<table>
<thead>
<tr>
<th>Does the person have access to other firearms/prohibited weapons?</th>
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<tbody>
<tr>
<td>YES</td>
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</table>

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

<table>
<thead>
<tr>
<th>Medical Practitioner</th>
<th>Psychologist</th>
<th>Reg/Enrolled Nurse</th>
<th>Social Worker</th>
<th>Counsellor</th>
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<table>
<thead>
<tr>
<th>NAME</th>
<th>CONTACT NUMBER</th>
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<th>SIGNATURE</th>
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Reporting Location (eg hospital, mental health hotline, private clinic, facility etc)

ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE

Version 3.0  February 2013