easternhealth
GREAT HEALTH AND WELLBEING

Continuing Care, Community and Mental Health

Mental Health, Turning Point Alcohol & Drugs

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24th October 2013.

Ms Claire Coates
Coroner's Registrar
Coroners Court of Victoria
Level 1
222 Exhibition Street
Melbourne VIC 3000

Dear Ms Coates,

Re: Investigation into the death of KATARINA S NOVAKOVIC

The Coroner made a recommendation connected with this death "that to increase the safety of patients with an emerging depressive illness, Eastern Health mental Health Services review its policy and clinical guidelines to ensure monitoring of therapeutic effectiveness in the high-risk commencement period for antidepressants is assessed according to best practice principles."

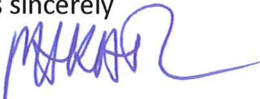
Eastern Health has reviewed this recommendation with the following outcome:

- It is controversial whether there is a possibility that selective serotonin reuptake inhibitors might induce suicide in some patients as the available data is uncertain regarding the actual risk of suicide attempts and death by suicide during antidepressant initiation and treatment and therefore controversial if there is a "high-risk commencement period for antidepressants".

- Neither the RANZCP clinical practice guidelines for the treatment of depression nor the clinical practice guidelines for the management of adult deliberate self-harm (which covers suicide) which are an indicator of best practice do not recommend an increase in monitoring of therapeutic effectiveness in the commencement period for antidepressants.

- An individual's risk and the clinical risk management are covered under the policy – "Eastern Health Program Clinical Risk Assessment and Management Practice Guideline". This policy identifies that there are both static risk factors and dynamic risk factors assessed which informs the overall assessment of risk and the therapeutic interventions. Commencement of antidepressant medication would be seen as a dynamic risk factor. (I have attached this comprehensive policy for your information).

Yours sincerely



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Mental Health Program Clinical Risk Assessment and Management Practice Guideline

Scope: Eastern Health
Executive Sponsor: ED Cont Care Community Mental Health and CAHO
Policy Status: Revised
Last Review Date: 26-07-2013

Policy Number: 1269
Approving Body: EH Clinical Program
Policy Developed: 01-04-2008
Next Review Date: 27-07-2015

Purpose:

This Practice Guideline is developed to meet the clinical requirements of the individual's accessing the Mental Health Program and aligns with the EH Assessment and Care Planning Standard

Details:

1. **Context**

This Practice Guideline is developed to meet the clinical requirements of the individual's accessing the Mental Health Program and aligns with the EH Assessment and Care Planning Standard. It has been compiled from the existing MHP Clinical Risk Assessment Policy and associated Practice Guidelines developed in 2010 and reviewed in 2013.

The Practice Guideline will inform all clinical staff employed within the Eastern Health Mental Health Program and State Wide Services (EHMHP&SWS) of the policy and philosophy when conducting risk assessment and ongoing management of a client's identified risk factors, in order to promote the most appropriate level of safety for consumers, carers, community and staff.

'Risk' is an abstract concept relating to the nature, severity, imminence, frequency/duration and likelihood of harm to self or others; a hazard that is to be identified, measured and ultimately prevented. It incorporates a consideration of both static and dynamic factors and it impacts variously at individual, interpersonal, organizational and community levels.

The assessment and management of risk in the mental health setting is an ongoing process from first contact and is tailored to meet the consumer's individual needs. It is an integral component of the overall care plan, which together, contributes to an environment conducive to safe and effective treatment.

Risk assessment starts at all entry points to clinical services via an initial phone assessment but the formal process of Clinical Risk Assessment & Management commences with 'face to face' contact and treatment processes and is then embedded within the continuum of care.

2. **Definitions of terms**

Risk: the potential for an adverse event or outcome.

Risk factors: any phenomena (static or dynamic) statistically related to a particular outcome

Risk assessment: in mental health is a clinical process through which risk factors believed to be associated with a hazard are identified

Risk formulation is an explanation of how risks in specified areas arise for a particular individual and involves an attempt to synthesize all the information to achieve understanding beyond an unstructured collection of data. It is the bridge between information gathering and care planning.

Risk management: aims to minimise the likelihood of adverse events within the context of the overall therapeutic aims of an individual. It provides the opportunity for targeted interventions to minimise the risk factors and to enhance the protective factors in order to achieve the best possible outcome, and deliver safe, appropriate and effective care. Key management activities address issues of: treatment (biological / psychological / social); placement (community / outpatient / inpatient / secure); restrictions (environmental / personal / legal); implementation (responsibility / communication / collaboration); monitoring and; (where necessary) victim safety planning

Gender sensitive practices: practice that recognises and responds to the differences, inequalities and specific needs of men and women and acts on this awareness.

Philosophy

The consumers, carers, staff of Eastern Health Mental Health and Statewide Services including Turning Point Alcohol & Drugs Programs (EH MH & SWS Programs) and the broader community have a reasonable expectation that the potential for unacceptable clinical harms/risks to any or all parties are identified and addressed in as effective a therapeutic manner as is reasonably possible.

Furthermore, Eastern Health holds to values that implicitly and explicitly emphasise a respectful and collaborative relationship that promotes safety, health and growth for all. Consumers have a right to be involved in their care and it's planning. Consumers also have the right to take responsibility for their actions.

Best practice principles will always guide the work of the clinician and the practice and policy development of the organisation.

Background

Harms/risks are clinically challenging phenomena within the mental health context that may or may not eventuate. Furthermore, living with the potential for harms and risks is a necessary part of the lives of consumers, carers and clinicians and is seen as 'core business' within the Programs.

In this context, harms/risks are viewed as those acts or events that may be self-inflicted (e.g. suicide), inflicted upon others (e.g. assault) or inflicted *by* others, (e.g. defrauding a consumer or the treatments prescribed). At all times the act of clinical intervention is balanced with the impact on an individual's liberty and general capacity, and the therapeutic benefits of allowing the consumer to take responsibility for his or her life and its direction.

The competent assessment and effective reduction of harms/risks is an ongoing process through the entirety of the consumer's clinical episode and, for a period beyond.

The violence risk assessment might have additional features for a community setting that may not be essential for an inpatient setting. Other risks being assessed would include risk of substance use or abuse and the risks contained within this – such as lethality or deteriorated mental health, risk of poor engagement in treatment, and so on. The evidence is clear - the focus of these assessments and areas of risk are different depending on the environment in which they are being undertaken. There are a range of assessment tools with varying degrees of evidence to support their efficacy in accurately predicting risk. Some are aimed at suicide or self harm risk identification specifically such as Beck's hopelessness scale, others aimed at prediction of violence or antisocial behaviours (HCR 20 Historical Clinical Risk, PCL-R Psychopathy Checklist Revised, VRAG Violence Risk Appraisal Guide), and one was reviewed that was

aimed at prediction of risk across all domains (GRiST – Galatean Risk Screening Tool) – this particular tool was over 18 pages in length when not used electronically but did provide for a graded level of risk assessment dependant on the findings at each stage. Unfortunately there is currently no published evidence of the effectiveness of this particular tool at predicting risk (2).

Recent literature consistently highlights poor capacity for clinical prediction of risk. Thus a key principle of this model is a focus on the prevention or minimisation of harms/risks that are reasonably foreseeable.

Purpose

This document has been developed as a point of reference and guidance for mental health clinicians in their clinical work. It offers a format of general guiding principles for dealing with harms/risks and articulates a model of reflection that is applicable at individual, team and organisational levels.

At a team level a description is offered as to the processes and use of service specific tools that support MHP's in structuring their professional judgement.

At an individual level it provides guidance as to best practice principles for use in clinical risk assessment and the subsequent management strategies recommended.

At an organisational level it provides a platform for the development of clinical risk assessment and management guidelines for all program areas.

Guiding Principles

1. A synthesis of research evidence, Mental Health clinician's knowledge of the consumer and their context, the consumer's own expertise and the mental health clinicians clinical judgement forms the basis of best practice.
2. A therapeutic risk management plan is developed by competent clinicians
3. Risk management is conducted in a spirit of collaboration underpinned by a therapeutic relationship
4. Recognition of the consumers strengths are integral to risk management and the planning of care
5. Recovery principles underpin the working relationship and the risk management plan
6. Responsibility for effective risk management resides at organisational, individual and consumer/carer levels
7. Flexible interventions are developed that prevent or minimise unacceptable harms
8. Awareness of static and dynamic factors can prevent or minimise unacceptable harms
9. Awareness and understanding of the range of legislation related to risk management is necessary
10. The risk management plan identifies current and reasonably foreseeable risks, the contexts that trigger or exacerbate the risk and clinician and consumer interventions to address the risk.
11. Assessment tools are used as indicated in policy and through local protocols to support a structured clinical judgement approach.
12. Interventions are congruent with the risks identified.
13. Mental Health Practitioners are sensitive to the consumers uniqueness regarding disability, religion, gender, age, culture and sexual orientation
14. Clinicians formulate their plans mindful that risk is a fluid concept across time and that a tailored approach is necessary for each consumer.
15. Risk management plans are developed in a shared way and in a spirit of openness and reflection. A non-blaming culture is valued
16. Mental health clinicians have regular access to initial and refresher training.
17. Communicating the plan to all stakeholders will be pivotal to its success
18. A process of regular formal and informal review of risk management is established within each team. This is further supported by regular clinical supervision

Decisions related to risk and its management are likely to be accepted if they:

- are developed in accordance with policy and relevant local guidelines
- are based on the best available information
- are documented
- are communicated to relevant groups and individuals
- are reviewed at appropriate intervals regarding their effectiveness

ELEMENTS OF RISK ASSESSMENT

- There are a range of factors to be explored when considering risk including:
- Gender and age
- Culture

- Supports – social and professional, strengths (internal and external)
- Mental state – hopelessness, despair, hallucinatory experiences, anger, shame, guilt
- Collateral information
- Family history
- Personal history/negative life experiences/ history of trauma
- Psychic pain
- Past medical history and Cognitive impairments
- Psychiatric history
- Confidence of the assessment
- Past history of risk/ previous suicide attempt - efforts to prevent discovery and regret upon survival convey additional risk
- Environmental considerations
- Stressors
- Relational or job loss
- Relationship history – supportive/protective/critical
- Substance use/abuse
- Coping strategies – previously used – successful/otherwise
- Peer group affiliation
- Willingness or ability to seek out or engage in treatment
- Perceived burden on others
- Personality structure – impulsivity, dependency
- Changeability of presentation
- Transition points of care
- Spirituality
- Access to lethal means
- Barriers to accessing healthcare – particularly behavioural healthcare
- Developmental stage

3. Name of EH Standard to which Practice Guideline relates

EH Assessment and Care Planning Standard

4. Processes

See attachment 1 Risk Assessment Document Map

Clinical risk assessment is undertaken at various points throughout contact with programs/teams within the MH and SWS Programs. Staff are required to undertake these assessments in collaboration with the consumer, their family or carers, and the multi-disciplinary treating (MDT) team. Consumers will be encouraged and, where clinically appropriate, supported to complete their own risk assessment in line with the principles of Recovery oriented practice. Where this occurs, the clinician will then discuss the risk assessment and appropriate strategies with the individual to reach a mutually agreeable position on the risks present and mechanisms to work with the risks.

Collaborative risk assessment allows for greater depth of assessment and clinical discussion regarding the risk assessment and subsequent management strategies required. Discussion with another clinician must occur at each point and be noted in the assessment and documentation. Rationale for risk mitigation strategies should be documented in the clinical progress notes to ensure that all members of the MDT, and the consumer, are aware of the reasons for particular interventions. The consumer and any carers should be informed of the strategies and interventions and discussion/negotiation of how to seek additional supports should occur.

It is imperative that all members of the MDT understand the requirements of particular interventions. Where specific strategies have been identified, this requires discussion and clarification at MDT meetings or nursing handovers to ensure that all staff members are aware of the requirements. For example: 1:1 nursing care – all staff should be aware what this means, what interventions are required during the 1:1 time, and what to do in the event of changing risk indicators.

Key points for initial or ongoing review or reassessment of clinical risks are:

- Triage/entry to all services (with the exception of CYMHS consumers aged 0-12 years – these are to occur where clinically indicated – pilot currently underway for new assessment format as at July 2013)

- *During times of crisis or change in presentation*

- Daily (as a minimum) on an inpatient unit

- Twice daily (as a minimum) for those consumers in a High Dependency Unit

- At every home visit undertaken by a CAT Team member

- At each 91 day review undertaken in a community program

- Upon exit or discharge from a program

The procedure varies for each program area within the MHP and SWS Program. Collaborative clinical risk assessment is beneficial to the individual experiencing the risks and to the clinical team providing support to the individual.

- It is expected that all risk assessments conducted are collaborative involving the individual receiving services, their family/carer/s (when appropriate) and treating teams.
- All assessments will be discussed with another clinician.
- Developmental and gender sensitive practices should be considered as part of both conducting the risk assessment, and with the interventions as clinically indicated.
- It is also expected that the rationale for risk management interventions are fully detailed within the clinical progress notes in addition to the discussion with another clinician.
- Specifically, in relation to NSMHS standard 10.4.5 when a Risk Assessment form is completed, the consumer's Treatment & Individual Recovery Plan is also reviewed to ensure that all documentation and collaborative plans are aligned.

The expectations regarding completion of clinical risk assessment and development of management strategies includes:

- The clinical risk assessment requires discussion between two clinicians and the individual to whom it relates. The second clinician should be the treating consultant or where not available at the time of the assessment the most senior clinician.
- When acknowledging a clinical risk assessment, the treating consultant (or the second clinician) does not need to have seen the consumer. The second signature or the name of the Consultant on the risk assessment form indicates that the consultant (or second clinician) has discussed the consumer with the first clinician, is aware of the risk issues (as assessed and reported by the first clinician) and has explored the management plan with the first clinician. It is also encouraged that the second clinician will explore with the first clinician the level of engagement from the consumer with regard to the assessment of risk and subsequent strategies.
- In community settings, discussion with the second clinician should occur, at the first clinical review of the consumer, at 3 monthly clinical reviews. Risk must be reassessed and clearly documented whenever the risk escalates or reduces. Again, collaborative involvement of the individual, their family/carer/s and other members of the clinical team is required when risk is reviewed.

Entry into Mental Health/AOD services – Clinical Risk Screening & Ongoing Assessment

Form number: EH 005100

The role of triage services varies slightly depending on the area this task is undertaken. Within the CYMHS and APMHS this function also includes a more in depth intake assessment over the phone or in person. Within the Adult MHP, this function is undertaken over the phone and provides information, referral or advice regarding suitable options for mental health treatment. Additional supports can be mobilised – such as crisis assessment by any part of the triage/intake services across all program areas. These areas are staffed by multidisciplinary teams of experienced mental health clinicians who specialise in all areas of assessment.

Risk assessment commences at the triage and then intake stage of any referral to public mental health services.

Triage services are tasked with identifying and actioning:

- requirement for public mental health services involvement
- level of risk
- level of service response required

Upon determining the above, referral to the most appropriate service component within agreed timeframes is undertaken.

Hence, risk assessment is an integral component to ensuring service delivery is appropriately undertaken in order to maximise therapeutic interventions in the safest manner available.

Initial risk screening is undertaken at the triage point, and is aimed at identifying all risks present within a referral.

- Telephone Triage risk assessment is undertaken in accordance with the existing triage templates (which contain a risk identification component) that is used by Triage/ Intake Services across the MH Program, and is to be documented on the CMI Screening Register.
- All clinicians undertaking face-to-face assessments must complete a Clinical Risk Screening & Ongoing Assessment tool (EH005100) to determine the types and severity of risks present.
- Completed tools are to then be provided to the service component that will undertake the next stage of assessment and/ or treatment. If the first point of contact with the MH Program is via triage telephone services, there will not be a completed EH005100 for the next point of the referral – the receiving service should, therefore, complete the EH005100.
- This initial screening is undertaken once for each new referral, or re-referral to these intake services. Where a risk screen has been undertaken in previous referrals, it must be done again to ensure that risk factors and indicators are assessed for the current referral time and presentation. Where this screen has occurred within 24 hours, it is only to be repeated where risk factors or presentation has changed; otherwise the initially completed screen will remain as current.
- Risks identified at this initial screen will support identification of appropriate level of service response regarding the referral.
- Any risks identified as "high" in one or more areas pertaining to safety of the consumer or others will result in referral to acute/urgent service response components (e.g. crisis response, emergency services response etc).
- Medium level risks identified in multiple areas (2 or more) will result in referral to alternative service components tasked with providing non-urgent support or assessment.
- Low level risks identified in all categories will result in referral to external service providers for more appropriate level of therapeutic engagement.
- Where clinical judgement determines that a referral to emergency/crisis/acute services is required, despite the absence of clinical risk indicators, this can still occur. Few or absence of high level risk should not preclude referral to acute or crisis based services if the situation is deemed to require that level and urgency of response. This would not be a regular occurrence as clinical risk is determined on a range of factors which generally inform urgency of response required.
- Where the level of risk is unclear due to inability to access information despite attempts via usual carer/GP/other service provider, discussion with the multidisciplinary team, consultant psychiatrist or senior clinician to determine the most suitable course of action regarding the referral should occur.
- Upon completion of the risk screening tool (when required), clinicians must ensure this information is provided to the receiving service at the time of referral, and in line with all other procedural requirements regarding making of referrals within our program areas.

Program areas include:

Children & Youth MH Access

AOD – Wellington House, Carrington Road, Turning Point, AOD Consultation Liaison

Dual Diagnosis

Adult MH Triage ED Response

CCT intake

CATT intake

MSTT intake

Consultation Liaison Psychiatry – CL

Aged Persons MH Intake

Case Management/Ongoing review

Form number: EH005100

Community Mental Health Services across the age spectrum provide medium to longer term community based treatment to consumers of public mental health services. The specific services provided vary depending on the program area. The range of community programs includes: Clinical Case Management with Continuing Care Programs, Mobile Support and Treatment Teams, Community Care Units (residential facilities), Aged Persons Assessment Teams, Specialist Youth Mental Health Teams and Early Psychosis Program.

Assessment of risk within community based settings requires highly developed skills. The ability to identify risk factors and indicators and combine these with a comprehensive mental state assessment in order to provide optimal therapeutic interventions within an array of environments whilst ensuring consumer safety is challenging. As the evidence suggests, predicting risk is not a definitive science and factors can alter without the knowledge of the clinician undertaking the assessment of risk.

Risk will be assessed in two parts which will inform the overall assessment of risk and the therapeutic interventions required.

Static risk factors will be assessed for all consumers within community based settings (residential or non residential). These factors are long term indicators of risk that largely remain unchanged – past history, family history, trauma, diagnosis and so forth. They seek to inform the chronic presentation of risk factors, which in turn can inform some of the dynamic risk factors.

Dynamic risk factors are those which are more susceptible to change – substance use/abuse, level of engagement with treatment, changes in mental state, alteration to medication, changes in support structures and so forth.

History of acts related to risk will inform the static risk assessment, and acts of harm to self or others will in time become part of the static risk assessment. For instance, current act of assault to others will in time be part of the history of clinical risk for that consumer, rather than a current risk. However, this same risk may remain a current risk (dynamic) if the circumstances are similar to when the original risk occurred – e.g. assault to parents after period of non-compliance with antipsychotic treatment and due to high level of paranoia.

This tool (Clinical Risk Screening & Ongoing Assessment) is to be completed for every case managed consumer, or those consumers receiving ongoing treatment from a community component. Program areas include:

- all AMHS Community Programs (CCU, CCT, PARC etc)
- all CYMHS Community Programs
- all Aged Community Programs

Completion should occur at a minimum upon:

- EVERY transition in care – i.e. referral into or discharge from service or on transfer from an EH IPU or case manager to an EH case manager, discharge from any IPU to any community team
- change in presentation
- referral to acute mental health services
- and at the 91 day case review (where applicable)
- where medications being prescribed are altered or the quantity and or combination are considered lethal in overdose

Acute Inpatient Mental Health Program

Form numbers: EH004800, EH005800, EH005200

Inpatient services are tasked with the provision of acute and intensive treatment to individuals who require this level of care. They are gazetted facilities where individuals can be provided with treatment as a voluntary or involuntary consumer under the Mental Health Act. Higher levels of observation and intensity of treatment is provided. They are staffed by multidisciplinary teams who are part of the overall public mental health system. The models of care vary across program areas.

Risk assessment within the acute inpatient services within aged persons, adult and adolescent units require specific assessment processes which support the principles of intensive mental health therapeutic interventions.

Consumers admitted to inpatient facilities are requiring intensive mental health treatment and often require more detailed risk assessment to ensure these treatments are provided safely within environments that are frequently changing. Regular new admissions, discharges, alterations to treatment, invasive treatments and an increasingly complex consumer group require an approach to risk assessment and management that is evolved and ongoing. Risk is an ever changing factor within these settings and as such multiple tools have been developed to support the work and environments within which consumers are receiving treatment.

Upon admission to an inpatient facility, within adult or adolescent mental health, consumers will already have a completed screening tool which will have provided an overview of risks identified at the point of triage or intake. This will be accompanied by a more detailed assessment of the risk factors, indicators, and proposed management strategies to ensure optimal treatment and care provision. This will have been completed by the service that undertook the detailed assessment which determined admission as being required. For consumers new to public mental health services, this will mean an initial risk screen done by triage/intake at point of referral, accompanied by a detailed risk assessment undertaken by the assessing service (CATT, ED clinician). For existing consumers, i.e. those already linked with mental health services, this will mean a detailed risk assessment undertaken by the clinicians involved with their care prior to admission. This risk assessment will have identified static and dynamic risk factors which will have contributed to determining the need for inpatient treatment. This may have been completed by the case manager, crisis or duty clinician, CATT clinicians, MSTT clinicians or CCU clinicians.

The next stage of risk assessment is undertaken upon admission to determine the specific risks during their inpatient stay that will require intervention.

This initial inpatient risk assessment will have several possible outcomes:

- requirement for interventions within the Low Dependency Unit (LDU)
- requirement for interventions within the High Dependency Unit (HDU)

Once this is ascertained, specific interventions or strategies that are required are to be documented on the appropriate inpatient tool.

All acute inpatient risk forms once scanned will be stored in the '**Admissions**' tab of CPF

High Dependency Unit Clinical & Risk Assessment

Form number: EH004800

High Dependency Units are found within inpatient units.

Due to the specific and highly intensive environment of an HDU and due to the body of evidence, a specific tool to assess and manage risk indications for consumers within the HDU has been developed.

This tool will allow for:

· Minimum of twice daily completion

· Minimum of one risk assessment to be completed by the medical team for each consumer in the HDU on a daily basis

· Recording of all functional/visual observations of each consumer in the HDU environment on the rear of the form in line with the Therapeutic Support and Engagement Guidelines

· Record of minimum twice daily mental state assessment - space on the tool itself for recording basic information regarding current mental state, which also informs the identification of risk for each consumer and provides a clear profile of each consumer allowing for increased objectivity of monitoring improvements in mental state over time

· Easily identifiable strategies being implemented to support optimal therapeutic interventions. Strategies must be discussed with the individual to whom they relate, be specific to the HDU environment and the level of care required, and be communicated to all clinical staff involved in the care of the individual. Risk management in this environment often requires unique interventions to maintain an optimal environment for recovery. This tool allows for individual requirements for each consumer to be clearly articulated and implemented with space for indicating specific or group strategies and tailored approaches to care.

Low Dependency Unit Clinical & Risk Assessment

Form number: EH005200

Risk assessment within the LDU environment carries unique identifiers also. Along with the standing identification of risks within the suite of assessment, factors pertaining to engagement in the treatment strategies and willingness to participate with service delivery must be examined closely. The full suite of indicators and factors will determine suitability for treatment within the open ward environment, the strategies that will be implemented and the level of observations required for each consumer.

Frequency of assessment will be determined by all of the above indicators but occur no less than daily.

Sexual Safety Risk Assessment

Form number: EH005800

Eastern Health Mental Health Service has a moral, professional and legal obligation to provide a safe environment to all people who use the service, as consumers, visitors or staff.

Service planning and delivery considers the individual needs of the consumer, including any gender specific needs. Literature shows that prevalence rates for some types of mental illness are different for women and men. It is known that women and men access and use health services in different ways. Women and men also experience mental illness differently.

Many consumers, both men and women, have had past experiences of physical, emotional or sexual abuse. Although it is important to recognise the needs of both genders, women are more likely to have experienced abuse of various kinds. These experiences may affect reactions to, and experience of, psychiatric treatment. For both women and men, all staff must respect consumer rights to privacy (physical privacy in addition to privacy of information), particularly for involuntary consumers (31).

Sexual behaviour among consumers with severe mental illness poses complex emotional and social dilemmas. Consumers admitted to the acute inpatient unit may have a diminished capacity to consent to sexual activity, may have specific sexual symptoms of their illness such as sexual disinhibition, and may be at risk of inappropriate sexual activity.

Consumers may be at risk as either the initiator/perpetrator or recipient/victim of inappropriate sexual activity. Such activities may make consumers vulnerable to embarrassment, damaged reputations, sexual abuse, rape, unwanted pregnancy and transmission of Sexually Transmitted Infections (STI's).

The Chief Psychiatrist's guideline on sexual safety states that any sexual activity in an adult acute inpatient unit is incompatible with the acute treatment environment and is unacceptable. In accordance with this, all inpatients of Eastern Health Mental Health Service are prohibited from engaging in any sexual activity, and staff members must take reasonable steps to try to prevent such activity. This is in the interests of ensuring a safe and therapeutic environment that promotes the recovery and wellbeing of each individual.

In addition, consumers may not have knowledge of or access to avenues of complaint about inappropriate sexual activity, and in some cases may have difficulty understanding what constitutes sexual assault. It is the responsibility of the treating team to ensure all consumers and carers are provided with the appropriate information.

Early identification of those who are vulnerable to risk of sexual activity, harassment, abuse or assault is required so that strategies can be implemented to manage the risk. Assessment of a person's sexual vulnerability should be a component of psychiatric and risk assessment along with other risks such as risk to self and others, risk of violence, physical health risk or other vulnerability.

Patients should be also assessed for their capacity to manage their sexual behaviour in hospital and, to the extent possible, identify strategies with them that might assist them to feel and keep safe. This should include assessment of mental status, level of orientation and level of understanding of the rules on the unit, including the psychological and physical consequences of sexual behaviour, such as pregnancy and infection.

All consumers on admission will have a clinical risk assessment and management plan conducted which will include sexual risk, this will enable early identification of those who are most at risk and who will require access to the "Gender Sensitive Area" in IPU's.

As with any risk, all Consumers who are identified as being vulnerable to, or at risk of sexual activity, assault or harassment must have a detailed treatment plan completed and reviewed daily by the treating team.

In some circumstances it may not be appropriate for a Female Consumer to have access to this area, i.e., those deemed at risk of self harm, those who may have a history of violence, aggression, substance abuse, property destruction and sexually inappropriate behaviour. In such circumstances where a Female Consumer is deemed inappropriate for bed placement in this area and no beds are available outside this designated area, then consideration should be made to open the electronic doors. Staff members should familiarise themselves with, and follow, Eastern Health's policy on 'Promoting sexual safety and responding to sexual activity in MHTPAD Program areas'. For example, in the event that a claim is made by a Consumer relating to sexual activity, assault or harassment, that policy is to be followed.

All staff members must take reasonable steps to ensure they are acting in a safe and appropriate manner with consumers at all times. This includes working in pairs wherever there are concerns about allegations of inappropriate conduct being made, where consumers are particularly unwell or disinhibited or where a staff member feels unsafe in working with a particular consumer for any reason.

Communication of any sexual risks must also occur from the IPU staff to the community case manager or ongoing treating team.

All consumers on admission will have a *clinical risk assessment and management plan* implemented which will include sexual risk. This will enable early identification of those who are most at risk and those who may require access to the "Gender Specific Area" in the IPU's. All acute inpatient consumers will have a Sexual Safety Risk Assessment completed on admission (form EH005800). This assessment must be discussed with the individual to whom it relates along with subsequent strategies to support the individual during their inpatient stay. Where high risks are identified, either of vulnerability or predatory behaviours, assessment will be undertaken on a daily basis thereafter. Use of the gender specific area in the IPU's (where available) is to be considered as part of the planning for each consumer.

Alcohol and Other Drug - Residential and Outpatient

Form number: EH005100

Eastern Health Turning Point Alcohol and other Drug Services include:

Statewide Services (Clinical services based at Fitzroy site) Eastern Metropolitan Region Services (Eastern Health Alcohol and Drug Specialist Services, including Wellington House residential withdrawal unit)

Assessment is to occur at all entry points into service delivery via the Clinical Risk Screening & Ongoing Assessment (EH005100) tool and upon discharge or exit from all service components as a minimum requirement. Where high level risks have been identified, specialist addiction medicine or addiction psychiatrist support should be sought, referrals

made or discussions with senior clinical staff to occur to ensure optimal therapeutic interventions are being provided in the safest manner possible.

Hence the requirements for AOD clinicians are:

· Completion at a minimum of entry and exit from each service component

· Where service is provided as a once only contact, then assessment occurs once and is documented once

· Where service is provided from multiple locations or by multiple clinicians from AOD, the service with the highest frequency of contact is to complete on entry and exit from that service – this should be discussed and documented at the outset of joint care

· Where multiple service components are involved in a consumer's care, the risk assessments are to be conducted by both service components with the focus of assessment being the focus of care provided. For example, risk assessment of a residential withdrawal client who is case managed by a mental health service will be assessed by the AOD service (as a minimum) on entry to the facility and again on discharge/exit (more often if indicated – see below) and the case manager from mental health services will conduct a risk assessment in line with their procedural requirements or more often if clinically indicated.

· Assessment is an ongoing process and level of risks may alter dramatically throughout the course of withdrawal. Additional risk assessments should be undertaken where there are/is:

o Previously unrecognised risk factors that arise during withdrawal care

o History of complex withdrawal in the past

o Current or past history of significant physical or psychiatric comorbidity

o One or more risks in the "high" category upon completion of initial risk assessment

Additional Risk Assessment for Features of Personality Disorder (Spectrum)

Form number: EH005000

Spectrum's Additional Risk Assessment for Features of Personality Disorder form sits alongside other risk assessments - it does not substitute for or take precedence over the risk assessments of primary clinicians located in AMHS or CYMHS services. It may however inform how risk is managed locally in relation to Personality Disorder.

The following conditions define where an Additional Risk Assessment for Features of Personality Disorder form may be used:

Secondary Consultation

General Assessment

Spectrum Direct Treatment

The tool must be completed for all clients entering Spectrum direct treatment. Where the tool has been used as part of a Spectrum general assessment process it should be reviewed on entry to direct treatment and the risk formulation updated if required.

During Spectrum direct treatment, risk should be reviewed, and when necessary the risk formulation updated, at each clinical review period. Risk review and reformulation may be done more frequently if required.

Risk should be reviewed and the risk formulation updated at the commencement of any residential treatment.

5. **Roles, Responsibilities & Behaviour** (What roles do staff and consumers/carers have and what are their specific responsibilities relating to achievement of the Practice Guideline? What are the behaviours required of staff and consumers/carers in order to deliver the Practice Guideline? Alternative roles may need to be specified in more detail depending on the Practice Guideline.)

Staff Group	**Roles and Responsibilities**
CEO	Ensure systems exist to measure clinical risk for all EH consumers
Executive Directors (including professional officers)	Commission development of appropriate Practice Guidelines to ensure adherence to EH Standards
Executive Clinical Directors	Develop and implement Clinical Risk Assessment guidelines Monitor and review performance to the guidelines
Clinical Directors	Develop and implement Clinical Risk Assessment guidelines Monitor and review performance to the guidelines
Directors, Program Directors, Associate Program Directors	Implement Clinical Risk Assessment guidelines Monitor and review performance to the guidelines
Department/Unit Managers	Ensure all staff are aware of and adhere to Practice Guidelines in Clinical Risk Assessment and management Ensure 3 monthly audit occurs within their unit, review results and implement actions to address gaps in performance to the Practice Guideline
Front line service delivery and support staff	Awareness of, adherence to the Practice Guideline in Clinical Risk Assessment and management Participation in 3 monthly audit process Actively seek feedback regarding Clinical Risk Assessment/Management processes Engage in professional and clinical supervision to ensure opportunity to reflect upon and enhance practices relating to Clinical risk assessment and management
Consumer / Carer	Participate in the Clinical Risk assessment process Guide clinical staff in the development of strategies to encourage positive risk taking and optimise safety during clinical interventions and treatment

6. **Skills, Knowledge & Competencies** (What information do staff need to know in order to support the achievement of the Practice Guideline? What do particular professional groups need to know? What do consumers/carers need to know to participate at an individual care level or program level? What training is required to support achievement of the Practice Guideline? How will this be delivered?)

Staff Group	**Skills, Knowledge Competency Required**	**Training Required**	**Delivery Mechanism**	**Responsibility**	**Timeframe**
All clinical staff	Clinical Risk Assessment and management	CRAM	PDU training calendar – face to face, online via MHPOD	Managers	Initially (within three months of commencement) Annual refresher

7. **Tools & Techniques** (What tools e.g. forms, documents exist to support the achievement of this Practice Guideline? How will the information and knowledge be managed, stored and shared?)

Forms for completion of clinical risk assessment and documentation to be completed for each program area:

1. Risk Assessment Document Map *(Appendix A)*
2. Clinical Risk Screening & Ongoing Assessment tool EH 005100
3. High Dependency Unit Clinical & Risk Assessment tool EH 004800
4. Low Dependency Unit Clinical & Risk Assessment tool EH 005200
5. Sexual Safety Risk Assessment tool EH 005800
6. (Spectrum) - Additional Risk Assessment for Features of Personality Disorder EH 005000
7. CYMHS Under 12yrs Clinical Risk Assessment form EH190210

8. **Measures** (What measures and mechanisms will be used to monitor compliance with the processes and performance against the Practice Guideline? Who is responsible for collecting the data and reporting it to the appropriate person and/or governance committee)

Measure	**Target**	**Date Target Due**	**Frequency of measurement**	**Person (role) responsible for collection**	**Person (role) accountable for target**	**Reporting line (committee)**
Quality of and adherence to the Practice Guideline requirements	80% compliance with all audit measures		Quarterly audit	MHP CRAM committee	Program Director, Executive Clinical Director	Reported to EH Clinical Executive quarterly

9. **Level of Supporting Evidence Available** (For Clinical Guidelines only – Level I –IV. Provide details.

10. **Practice Guideline Risk Rating** (What is the risk of not meeting this EH Practice Guideline? Link to existing Eastern Health Risk/s)

What may potentially happen if the <Insert standard name> is breached or standard not achieved using EH Risk Tables and Matrix .	**Consequence Rating**	**Likelihood Rating**	**Risk Rating**
Potential for clinical risks to lead to adverse outcomes for consumers	Catastrophic	Occasional	HIgh

11. **References** (List references used in the development of the Practice Guideline.)

DH Guidelines on working with the suicidal person

Office of the Chief Psychiatrist : Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units

1. EH Clinical Risk Assessment Policy 2011

2. Department of Health: Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services (2010)
3. NSW Department of Health (2004) Suicide Risk Assessment and Management Protocols, Mental Health Inpatient Unit
4. Sexton, P (2009) The assessment and management of risk within Cumbria partnership NHS Foundation Trust
5. HACSU (undated) Guidelines for Clinical Risk Assessment and Management
6. Boyce, P (2004) Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm. Australia: Australian and New Zealand Journal of Psychiatry
7. Katz,P & Kelly, B (2008) Risk Assessment Paper. Melbourne
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9. Spectrum Risk Management Approach (undated) Melbourne: Spectrum State wide Personality Disorder Service
10. Chiles & Strosahl (2005) Assessment of suicidal behaviour and predisposing factors
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14. Ortiz, M (2006) Staying Alive! A suicide prevention overview. Journal of Psychosocial Nursing
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17. McSherry, B (2004) Risk Assessment by Mental Health Professionals and the prevention of future violent behaviour.
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19. Oldham, J ( ) Borderline Personality Disorder and Suicidality
20. NHS Foundation Trust (2009) Integrated Clinical Risk Policy
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22. Paley, G & McGinnis, P (2003) Implementing a Trust-wide Strategy for Clinical Risk in Mental Health. Mental Health Practice Journal
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26. Fourth National Mental Health Plan
27. The Gender Sensitivity and Safety in Adult Acute Inpatient Units project final report, Victoria, Department of Human service, 2008.
28. Promoting Sexual Safety, Responding to Sexual Activity, and Managing Allegations of Sexual Assault in Adult Acute Inpatient Units, Chief Psychiatrist Guideline, Victorian Government Department of Health, Melbourne, Victoria Updated June 2012.
29. Eastern Health Mental Health Inpatient Service 'Responding to Allegations of Sexual Activity' policy 2010.
30. Eastern Health Mental Health Inpatient Service 'Promoting Sexual Safety on Inpatient Units' brochure 2012
31. Department of Human Services, 'Because Mental Health Matters - Victorian Mental Health Reform Strategy 2009-2019', 2009

12. **Development History** (Detail the history of development and review including a summary of major changes.

Initially developed 2008 as basic CRAM policy.

Full review of Clinical Risk processes undertaken in 2010, lead to development of CRAM Practice Guidelines

Now updated 2013.

13. **Attachments**

Risk Assessment Document Map

Policy Upload:

1269 CHECKLIST MHP Clinical Risk Assessment and Management.doc

Additional Documents:

Risk Assessment Document Map.doc

Keywords - Clinical risk mental health assessment suicide aggression CRAM