West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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13 June 2022

9(2)(a)

[redacted]

RE Official Information Act request WCDHB 9688

I refer to your email dated 19 April 2022 requesting the following information under the Official Information Act from West Coast DHB, on how the DHB undertakes suicide risk assessment to inform decisions on access to services. Specifically:

1. **Full descriptions and/or a copy of the *measurement tool(s), procedure(s) or method(s)* used to assess the *risk* of *suicide or self-harm*, informing decisions on providing access to the *DHB's services*.**
   - **By "measurement tool(s), procedure(s) or method(s)", I mean how risk is determined, which may also involve any of the following (but not limited to these): surveys; protocols; checklists; questionnaires; scales; instruments; screening tools; inventories; evaluation tools; scores; an index or indices; psychometric tools; psychological tests; psychiatric tests; ratings; interviews; items; forms; status forms; decision trees; pathways; safety plans; template; risk stratification; formulation or risk formulation; action plan; risk banding; risk categorisation. These may feed into a "traffic light system" that categorises individuals according to varying degrees of risk.**
   - **By "risk", I mean the probability (of suicide or self-harm occurring). The measurement tool(s)/procedure(s)/method(s) in question may refer to any of the following terms (but not limited to these): likelihood; possibility; potential; prediction; danger; hazard.**
   - **By "suicide" I mean an individual taking their own life. By "self-harm" I mean an individual intentionally damaging their body, with or without suicidal intent. The measurement tool(s)/procedure(s)/method(s) in question may use other terms, including the following (but not limited to these): attempted suicide/suicide attempt; suicidality; self-injury; self-injurious behaviour; parasuicide.**
   - **By "the DHB's services", I mean those services related to all ages, all teams, all specialities, including but not limited to mental health, inpatient and outpatient, Emergency Department, EIS/Early Intervention, maternal mental health, cultural teams, youth forensic services, older adult, dual disability, liaison psychiatry, emergency psychiatric service, crisis team. Hence, I request information regarding *any* DHB service where suicide risk is assessed during decisions on service access.**

Please refer to the following Appendices:

Appendix 1 - Clinical Risk Assessment and Management Protocol
Appendix 2 - UK Mental Health Triage Scale
Appendix 3 - After Hours Mental Health Triage Procedure
Appendix 4 - ISBAR Handover for Crisis Response Multi-Disciplinary Meeting

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

Clinical Risk Assessment and Management Protocol

Purpose

This Protocol outlines the West Coast District Health Board (WCDHB) Mental Health Service (MHS) philosophy, principles and practice of Risk Assessment and Management which guides clinical care.

Policy

All Mental Health Service Clinicians will seek to minimise the likelihood of adverse events by:

- Conducting a clinical risk assessment based on the structured clinical risk assessment framework.
- Utilise additional specific risk assessment tools where relevant such as Family Safety Screening, DASA or HCR20. The use of these additional tools should only be used following the appropriate training.
- Implementing effective clinical risk management strategies.
- Documenting the assessment, risk scenarios and management strategies.
- Communicating Risk Assessment and Management Plans with consumers and their family/whanau/caregivers (unless clinically indicated not to).
- Ensuring that clinicians are competent to carry out risk assessment and know when to seek a more specialised assessment.

Applicability

This Protocol is to be followed by all WCDHB MHS Clinicians involved in the care and treatment of consumers regardless of their legal status and is an integral part of their clinical care. All Clinicians are responsible for assessing and monitoring risk in line with their Scope of Practice.

Definitions

For the purpose of this Protocol:

The **Consumer** is taken to mean a person who is suspected of experiencing or has experienced a mental illness and who uses or has used a mental health service.

The **Multi-Disciplinary Team (MDT)** is a team of health professionals from different disciplines including nursing, medicine and allied health, scientific & technical, who provide co-ordinated, comprehensive, consumer-focused care.

The **Community Case Manager** is the clinician responsible in the community mental health setting to coordinate treatment planning and ongoing care.

The **Community Team (CT)** is a team of different health professionals, based in the community, who support consumers living in the community through their mental health and/or addictions experience. This will include CAMHS, AOD, Crisis Response and the locality based adult Community Mental Health Teams. The CT may include clinicians from more than one team.

The **Manaakitanga Inpatient Unit** is a 9 bedded acute mental health unit for the West Coast region.

Risk is taken to mean the likelihood of particular adverse events occurring with a particular consumer under particular circumstances within a specified period of time. Risk refers to all forms of risk to self and to others.

Risk assessment is a process of clinical evaluation to determine risk, including the likelihood, imminence and severity of risk. This includes developing a detailed clinical picture of the consumer (past and present), documenting the characteristics and situations where particular behaviours have occurred, identifying possible consequences of risk behaviour and noting previous effective and ineffective interventions and outcomes.

Risk factors are the particular features of an illness, behaviour or consequences that alone or in combination lead to an increased risk.

Risk management is the development and implementation of an effective intervention plan which aims to reduce the level of risk to the consumer, family/whanau, others and property based on the risk assessment and at-risk scenarios.

At risk scenario identification is a clinical judgement made by an adequately trained mental health clinician.

A **Duly Authorised Officer (DAO)** is a registered staff member who is trained and approved to support the enactment of the Mental Health Act.

Health Connect South (HCS) MH Solution Portal is the computer system used by WCDHB to record consumer's information. This system is the consumers electronic Clinical File.

Clinical File is taken to mean the consumer's individual clinical file, in which is recorded all information pertaining to their care and treatment as per the WCDHB Clinical Documentation in Mental Health Service Procedure. Clinical File refers to a consumer's hard file as well as electronic file.

Roles and Responsibilities

For the purpose of this Protocol:

The **Community Case Manager** or the **Manaakitanga Inpatient Primary Nurse** or the **Crisis Response Service staff members** are the clinicians responsible for ensuring formal risk assessment and management planning is completed for the consumer.

The **Multi-Disciplinary Team (MDT)** is responsible for supporting the Case Manager in formulating and reviewing risk assessment and management planning.

Policy measurement

Assessment

- Risk assessment is ongoing and is part of all clinical interactions. It should include:

- Identification of an individual's static risk factors - situations that are historical (that is, they have already occurred) or are enduring - (factors that lead to risk relative to others in a stated population). This could include information from previous contacts with mental health services.
- Information from risk incidents should include a factual description of:
    - when they occurred
    - what happened
    - the context (including if possible, an understanding of the dynamic internal and dynamic situational risk factors at the time)
    - the outcome of the risk event
    - the consumer and their family/whanau's view on what the intent of the risk behaviour was
- Identification of dynamic internal factors - consumer's current mental state (this includes mental illness, but also includes other states such as fear, anger, helplessness etc) and the consumer's current physical state which could impact on their risk (for example dehydration, delirium, hypoglycaemia, intoxication).
- Identification of the dynamic situational factors are factors that are external to the consumer. These can, for example, include factors such as access to means for suicide or harm to others for example weapons, loss of relationships, housing or income, or the actions of other people that affect the consumer's risk.
- Consumer's strengths and protective factors for risk reduction, from the perspective of the consumer.
- The viewpoints of family/whanau/caregivers about the current risk and possible risk management strategies.
- At times utilising additional risk assessment tools such as the HCR20 and DASA (for violence risk assessment).
- Consider long term risk vs more acute changes in presentation. Longitudinal information from family/whanau or significant others can highlight important fluctuations in presentation that are not apparent at the time of assessment.
- Assessment of family and child safety issues should follow the relevant WCDHB policy (Management of Child Abuse and Neglect Policy & Procedure).

At risk scenarios

Risk assessment must lead to the identification and description of scenarios that are likely to result in risk behaviours.

At risk scenarios are a structured description of the risk information that has been recorded in the history and dynamic internal/situational sections. Scenarios can also be informed by clinical reasoning. A consumer might require more than one scenario as different pathways to violence and suicide may have been identified from the risk assessment.

Scenarios should describe the nature and context in which the risk behaviour is most likely to occur, including internal and situational factors that increase the risk. Scenarios should also incorporate statements regarding seriousness, imminence, who the likely victim/s might be, and the availability of the means and opportunity to carry out the harm.

Management

Risk management plans should be discussed with the individual consumer and their family/ whanau, unless clinically contraindicated, before being enacted.

The management plan should identify interventions for the consumer that will reduce or contain risk behaviours, including:

- Interventions to address dynamic situational risk factors contributing to risk (for example, use of medication, use of 'talking' therapies).
- Interventions to address dynamic situational risk factors contributing to risk (for example, use of medication, use of 'talking' therapies).
- Interventions to address situational factors contributing to risk (for example, interventions to address social stressors including relationships, accommodation and financial situation, access to alcohol and illicit substances, access to weapons, access to potential victims).
- Strategies for building on existing strengths and protective factors to reduce risk.
- Resources which are immediately accessible to the consumer, family/whanau and MDT to support risk reduction.
- 'Guarantees of safety' or 'no-suicide' contracts are contra-indicated and are not to be asked of consumers by clinicians.
- In certain situations, (continued) admission to hospital will be appropriate, including the potential use of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The management plan must reflect the changes to risk over time, given the dynamic nature of risk.

Risk management strategies should show why strategies were chosen for an individual. In some circumstances it is useful to briefly describe why other strategies were not used (for example, these may have proved unhelpful for the consumer at previous times, or the consumer or family considered they would increase risk, or the resource may not have been available).

Risk management strategies should reflect each risk that has been identified.

Management of family and child safety issues should follow the relevant WCDHB policies.

Documentation

Location

MH Solutions Portal in Health Connect South is the primary place for risk to be documented.

A clinician who does not know a consumer should be able to find key information in the MH Solutions portal. It should be of a practical nature to assist the clinician to understand high risk situations and the suggested management and intervention strategies for these.

The Summary of Risk reflects a structured clinical risk assessment framework and is completed for each consumer assessed in the Mental Health Services.

Relationship to other documents

Assessment and Discharge Summaries: - A statement about risk should be included in all Assessments and Discharge Summaries. This should be a statement about contextual risk, not whether or not that person is considered a low, medium or high risk at that point in time. This should reflect the risk scenarios and management sections from the MH Solutions Portal. Other significant risks such as child and family protection issues should be part of this.

Treatment Plan: - Overall risk management strategies should be documented in MH Solution Portal on HCS. The Treatment Plan, Relapse Prevention Plan and Crisis Plans are the documents shared with the consumer and family/whānau so they must contain relevant aspects of the risk management strategy.

Clinical Progress Notes: - Day to day assessments of risk should be noted in clinical progress notes with any significant changes transcribed to the Summary of Risk document.

Responsibility for documentation

Responsibility for the formal risk assessment generally lies with the clinician most involved in the consumer's care, usually the Community Case Manager or Manaakitanga Inpatient Primary Nurse or the Crisis Response Service but in an emergency situation this may be a DAO or anyone else responsible at that point in time.

Updating risk information should be completed by the person undertaking the risk assessment at any point in time. Other clinicians who are given new risk information are responsible for both informing the consumer's usual coordinating clinician and for documenting this information themselves.

The Case Manager or key clinician is responsible for ensuring that the Individual Treatment Plan and Relapse Prevention Plan is current and incorporates risk management strategies.

Any significant increase in risk must be documented before the clinician finishes work for the day.

Review of Risk

When to review:

Appropriate intervals for reviewing and documenting risk changes include:

- A consumer's first contact with Mental Health Services
- A consumer's admission to hospital
- Clinical Progress Notes once every shift (if the consumer is an inpatient)
- Formal clinical review
- Change in legal status
- Significant change in leave status
- Referral or transfer to a new service
- Discharge from a service or Manaakitanga Inpatient Unit
- Any change in risk for any reason including following a risk event
- If family/whanau report concerns
- Any significant change in consumer's mental state

Associated material

Controlled documents

- AWOL Checklist
- AWOL Forms
- CMHT ISBAR Handover Form
- IPU Admission and Discharge Checklist
- IPU Manaakitanga Inpatient Unit Fireboard
- Missing Persons Form

Supporting documents

- WCDHB Family Violence Policy and Procedure Manual
- WCDHB Clinical Documentation in Mental Health Service Procedure
- WCDHB CMHT Consumer Concern Procedure
- WCDHB Did Not Attend Service Procedure
- Mental Health Service Staff Safety in the Community Procedure
- WCDHB Manaakitanga Inpatient Absence Without Leave (AWOL) Procedure
- WCDHB Observations in Manaakitanga Inpatient Unit Procedure

References

New Zealand Standards and Legislation

- Health Information Privacy code 1994
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1999
- NZS 8134: 2008 Health and Disability Services (General) standards
- Privacy Act 1993

Supporting research

- MOH 2016) Preventing Suicide: Guidance for emergency Departments
- MOH (2013) New Zealand suicide prevention action plan, 2013-2016
- MOH (2006) Assessment and management of risk to others: Guidelines and development of training toolkit.
- MOH(2005)Suicide Prevention: A review of risk and protective factors, and pointes of effective intervention
- MOH (2000) Involving families' guidance notes: Guidelines for involving families and whanau of mental health consumers/tangata whai ora in care, assessment and treatment planning.

APPENDIX 2

UK Mental Health Triage Scale				
Triage Code /description	**Response type/ time to face-to-face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). *International Journal of Mental Health Nursing.*

After Hours Mental Health Triage Procedure

Purpose

This procedure outlines the process to be followed by West Coast District Health Board (WCDHB) Mental Health Service staff around the management of triaging telephone contacts after hours and to ensure that all calls are appropriately responded to in a timely manner.

Application

This Procedure is to be followed by all WCDHB staff that work within the Mental Health Services.

Definitions

For the purpose of this Procedure:

After Hours is taken to mean the time outside of normal business hours (between 1630hrs - 0800hrs on weekdays and 24hrs on weekends and Public Holidays). During these times all crisis calls are to be directed to Home Care Medical.

Triage is a clinical process by a mental health clinician where they undertake an initial screening and assessment of a consumer to determine the type and urgency of the response required from specialist mental health or other services. If specialist mental health services are not the most appropriate option for the consumer, they may be referred to their GP.

Consumer is taken to mean a person who is suspected of experiencing or has experienced a mental illness and who uses or has used a mental health service.

Home Care Medical (HCM) is a telephone triaging service who provide after hours triage for the WCDHB and is staffed by Registered Nurses who are trained in mental health.

WCDHB Crisis Response Service is mental health staff who will attend and undertake an urgent after hours assessment of a consumer who may be experiencing acute mental distress. These staff may also be Duly Authorised Officers (DAO) who can provide assistance and support whenever requested in the application of the compulsory process of the Mental Health Act.

Responsibilities

For the purposes of this Procedure:

Home Care Medical are responsible:

- For triaging all crisis calls after hours and providing to WCDHB comprehensive information and risk information about a consumers current clinical presentation. Home Care Medical send this information to the Crisis Response Team via e-fax on 03 769 7504 immediately following triage phone call. If an urgent response is required Home Care Medical will also phone.
- Will only use the UK Mental Health Triage Scale to assess a consumers risk and urgency of response. If an urgent response/assessment is required by the WCDHB Crisis Response Service they will make immediate contact via Grey Base Hospital Main Reception pager/cell phone system to facilitate this. If a non-urgent response is appropriate this will be followed

up on the next working day by either the Crisis Response Service or the appropriate regional Community Mental Health Team.

WCDHB Crisis Response Service staff are responsible:

- For all staff to be responsive to urgent calls and prioritizing as appropriate.
- Liaising with Emergency Services such as Police and Ambulance, ED Department, Manaakitanga Inpatient Unit and Community Mental Health and be prepared to lead and support the use of the Mental Health Act if required.
- All Crisis Response staff are responsible for ensuring they have their pager with them at all times. If there is no response within 15 minutes from the pager Grey Base Hospital reception staff phones the 1st on-call Staff member.
- All staff are responsible for ensuring that multiple contact details are available.

Resources Required

- UK Mental Health Triage Scale
- Home Care Medical Triage documentation
- WCDHB Comprehensive Assessment, Risk Assessment and/or admission documentation – most current information if available is on Health Connect South
- Mental Health Act documentation
- ISBAR handover form

Process

1.0 Home Care Medical receives phone call from either the consumer, their family/whanau, Police or other which is triaged according to the UK Mental Health Triage Scale.

2.0 For consumers that present to the Emergency Department or the Police and there are mental health concerns they will follow their own triage process and if required will contact Home Care Medical who will follow their own triage process and escalate if required.

3.0 If a degree of urgency is required this will either be Scale A, B or C. If a semi-urgent response is required (within 72hrs) this will be Scale D. If a non-urgent response is appropriate this will be Scale E. Scales F and G are outside of mental health services such as GP or other primary NGO.

4.0 On occasion information about a consumer who is scaled E or F is sent through to the appropriate regional locality team. This is to provide them with information should the scale escalate.

5.0 For those triaged Scale A, B or C Home Care Medical will e-fax and phone the Crisis Response Service the relevant comprehensive information as well as risk information about a consumer's current clinical presentation.

6.0 For those triaged Scale D and E relevant information will be sent to the regional locality Community Mental Health Team (Northern, Central or Southern).

7.0 Information is sent by HCM to the appropriate service as per their Home Care Medical Triage Document and includes:

- Date and time of call

- Identification of the caller and relationship to person of concern
- Specific concerns of the person phoning, safety and risk information
- Exploration of the current situation and what has lead to this situation developing
- Whether the person needs to be seen at this time or can wait until the morning
- The person's willingness to be seen by Mental Health Services and their current location
- Exploration of previous history and contact with Mental Health Services
- Specific advice regarding Mental Health Act processes if applicable
- Brief supportive intervention focused on resolution of immediate concerns (as per a consumer's Crisis Plan or Relapse Prevention Plan)

8.0 WCDHB Crisis Response staff are to be contacted after hours only when it is clear as per the UK Mental Health Triage Scale that an urgent response is needed (Scale A, B, or C) or specific DAO assistance is requested to undertake the Mental Health Act process.

9.0 If there is no imminent risk or immediate response required as per the UK Mental Health Triage Scale (Scale D or E), and the consumer is considered to be safe overnight, WCMHS Crisis Response staff may if appropriate or necessary facilitate a phone call to offer supportive advice and/ or to assist with immediate management of current distress. For existing consumers, they will be followed up by their Community Mental Health/ CAMHS or AOD Case Manager on the next working day. For new consumers, Crisis Response staff will follow up with them on the next working day.

Precautions and Considerations

The key aspect of telephone triage is the focus on the gathering of sufficient information in which to accurately determine the required level of response.

WCDHB Crisis Response staff are to ensure that all documentation received from Home Care Medical has the appropriate information to facilitate the required level and urgency of response.

This includes:

- Ensuring faxed information is received promptly and that this is followed up with a phone call if needed to ensure the appropriate response is facilitated.
- Awareness of the possible need to contact Emergency Services such as Police or Ambulance to ensure the safety of consumer, family or others.
- A clear understanding of the consumer's concern and the appropriate action that is required in which to support them.
- Awareness of any external risks – firearms or dangerous animals on property, history of aggression, current AOD use, isolation, who else is present as well as the ability to drive or arrange transport to Hospital.
- If the information supplied is not adequate Crisis Response staff are to contact Home Care Medical to request additional information.

Associated material

- UK Mental Health Triage Scale
- Referral from Home Care Medical following triage
- Any relevant mental health documentation, as required for triage, assessment and follow up of care.
- WCDHB MHS Service Provision Framework
- WCDHB MHS Policies and Procedures

References

Health and Disability Sector Standards NZS 8134:2008.

APPENDIX ONE

UK Mental Health Triage Scale				
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APPENDIX 4

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Consumer Label

ISBAR Handover for Crisis Response Multi-Disciplinary Meeting

I	IDENTIFY	**Consumer Name:** _____ **NHI:** _____ **Address:** _____ **Phone:** _____ **DOB:** _____
S	SITUATION	**Presenting Complaint:** *(can be transferred from Triage Form / Comprehensive Assessment)*
B	BACKGROUND	**Relevant History:** *(can be transferred from Triage Form / Comprehensive Assessment)*
A	ASSESSMENT	**Current Assessment including Risks:** *(can be transferred from Triage Form / Comprehensive Assessment)*

R	**RECOMMENDATIONS, UPDATES AND ACTIONS REQUIRED**	**Date: _____ Staff Present: _____** **Date: _____ Staff Present: _____** **Date: _____ Staff Present: _____** **Date: _____ Staff Present: _____** **Date: _____ Staff Present: _____** **Date: _____ Staff Present: _____**

If Consumer is discharged, please file in Clinical File.

If Consumer remains under Crisis Response, please leave in handover file and attach additional sheet.