Director of Forensic Disability
PROCEDURE

Title: Clinical Risk Assessment and Management

Purpose

This procedure is issued by the Director of Forensic Disability in accordance with section 91 of the *Forensic Disability Act 2011* (the Act).

This procedure:

- provides direction for staff of the Forensic Disability Service (FDS) to undertake risk assessments and develop and implement risk management plans in order to ensure care, support and safety of clients, staff and the community.
- outlines the tasks to be undertaken to meet the statutory requirements of the Act for risk assessment and management.

Procedure

1. Risk Assessments

1.1 Forensic risk assessments

Forensic risk assessment involves the measurement of risk factors that have been identified as being associated with an increase in the likelihood of re-offending. Forensic risk assessment should include assessment of static and dynamic risk.

The main goal of forensic risk assessment is to:

- assess a client's likelihood of future risk of re-offending;
- provide clinical data to determine appropriate programs that have the potential to produce meaningful change; and
- inform risk management plans to manage or reduce risk and provide safety for the community.

Appropriate risk assessments should be determined by the Senior Practitioner and clinical treating team. Examples of assessments that may be considered appropriate can be found in Attachment 1.

1.2 Functional Behaviour Assessment

Assessment and management of clinical risk should be aligned with positive behaviour support (refer to *Director of Forensic Disability Policy – Positive Behaviour Support*) and trauma informed care (refer to *Director of Forensic Disability Policy – Trauma Informed Care*) approaches. Therefore, in addition to forensic risk assessments, further assessment may be undertaken to understand the

function of offending behaviour(s) or behaviour(s) of concern (that may be different to the client's offending behaviour). Functional behaviour assessment should consider how factors related to the client's disability, trauma history and the physical and social environment may influence the client's behaviour. Identifying functions of behaviour will assist in understanding and managing risk.

Functional behaviour assessment should aim to identify the function or purpose of the behaviour and should include determining the setting events and antecedents that precede the behaviour, specific information about the behaviour, including how it presents, escalation patterns, and its consequences. Assessment should involve consideration of the likelihood of the behaviour occurring and the impact on the client or others if not managed properly.

2. Risk summary

Information gathered through undertaking assessments and reviewing historical assessments/reports will inform the development of a risk summary. A risk summary will aim to bring together diverse clinical information to develop a concise account of the relevant risk variables that will inform risk management plans and guide decision making.

A risk summary is a means of communicating the most important, risk relevant information about the client and will assist staff and the client to better understand the client's risk. A risk summary should aim to:

- be simple, coherent, and informative;
- identify the likely causes of a specific client's behaviour;
- be underpinned by evidence-based assessment of the client's risk and current research/literature;
- link the relevant pieces of the client's story;
- offer guidance on the developmental origins and trajectory of the problem; and
- generate hypotheses for action to bring about positive change.

A risk summary will inform rehabilitation strategies/intervention and supervision and monitoring requirements.

3. Risk management

A risk management plan must be developed as part of the IDP. As the IDP is the responsibility of the Senior Practitioner they must be satisfied that the risk management plan contains sufficient information to guide staff in their care and support of the client.

The Senior Practitioner may choose to review the risk management plan at any time in addition to the regular three-monthly IDP review, ensuring that any updated IDP is communicated and provided to the client, all staff and the IDP review stakeholder group.

The risk management plan should contain:

- Risk management strategies for when the client is at the FDS;
- The proactive strategies to mitigate forensic and other behaviour risks taking into account the client's offence history and pathway, and conditions made by MHRT or Senior Practitioner;

- A clear description of behaviour(s) that may be exhibited by the client that may be linked to offending behaviour or behavior of concern, including stages of behaviour escalation;
- Reactive strategies to de-escalate or cease behaviour of concern, reduce risk and ensure the safety of the client and others, commencing with the least restrictive approach;
- Information about risks in relation to clients' accessing specific items and decisions regarding the management of client access to such items;
- Information and strategies about risk of self harm and or suicide where relevant; and
- Where a positive behaviour support plan (PBSP) is in place for a client, the IDP must clearly refer to the current PBSP.

The risk management plan should be communicated to the client to support their understanding of their own risk factors, and what they can do and what staff will do, to reduce risk.

When managing clients for whom the offence leading to the Forensic Order is a prescribed offence, the Senior Practitioner and supporting staff must take into consideration the serious nature of the prescribed offence, the need for a high level of oversight and the need to protect the community (refer to *Director of Forensic Disability Policy – Clients for whom the offence leading to the Forensic Order is a Prescribed Offence)*.

3.1 Proactive strategies

The IDP should contain proactive strategies to reduce risk of behaviours of concern and offence related behaviour. Strategies will be developed in consultation with the client, as appropriate, and relevant staff involved in implementing the plan. These strategies should be individualised and may include:

- The provision of specialist staff models and/or programs that directly target criminogenic risk factors;
- Participation in habilitative programs or activities;
- The development and implementation of a positive behaviour support plan;
- Increasing client skills and opportunities to use new skills;
- Developing the person's ability and opportunity to communicate;
- Ensuring a client feels safe and supported at the FDS;
- Using a trauma-informed care approach; and
- Supporting clients to develop personal coping mechanisms.

Relational security can be effective in reducing risk, and it is important that staff understand clients and their patterns of behavioural escalation. Risk management planning should consider how the interaction between staff, clients and the environment (social and physical) can increase the safety of clients and others. The risk management plan should note specific relational security measures that should be considered in supporting the client. Important relational security concepts include:

- Communicating and maintaining boundaries with clients;
- Setting a good example and supporting clients to practice new skills and assist them to believe in their individual development;
- Being aware of clients whereabouts at all times;
- Being aware of how clients interact with each other;
- Being aware of what may be affecting a client's emotional and mental state;
- Being aware of the physical environment;

- Understanding the impact that visitors may have on clients; and
- Staying alert for signs of unusual client behaviour and responding quickly and appropriately.

3.2 Reactive strategies

The risk management plan within the IDP should outline reactive strategies for when a client exhibits identified behaviour of concern. Strategies should be developed in consultation with the client, as appropriate, and relevant staff involved in implementing the plan. The aim of reactive strategies is to de-escalate a behaviour safely and quickly. Reactive strategies should be individualised and may include but not be limited to:

- Giving the person what they want/ need (if it is safe to do so);
- Removing the stimuli or situation causing the behaviour (if known);
- Changing the environment or social setting;
- Redirecting the client to a preferred activity or interaction;
- Distracting the client using a different stimuli; and
- Regulated behaviour control (only as last resort and only when least restrictive).

As clients at the FDS are likely to have experienced traumatic stress in their life, it is crucial for staff to understand (and avoid wherever practicable) the profound re-traumatising impact of strategies (e.g. regulated behaviour control, environmental changes) and any other identified triggers.

4. Individual Development Plan (IDP)

Risk assessments and risk formulation will inform the IDP, and will assist in identifying rehabilitation and habilitation goals, rehabilitative programs and interventions, Limited Community Treatment (LCT) and reintegration planning. The IDP will contain a risk management plan. An IDP will be developed within 21 days of admission (refer to *Director of Forensic Disability Policy – Individual Development Plans*). The risk management plan with the IDP should include proactive and reactive strategies to support the client and reduce the likelihood of behaviour of concern.

The Senior Practitioner will decide whether to develop a PBSP (refer to *Director of Forensic Disability Policy – Positive Behaviour Support)*. Where a PBSP is developed, the IDP should provide a brief summary of the PBSP and refer staff to the plan for implementation.

In the event that staff are uncertain as to how to proceed in relation to a client, staff should consult the Senior Practitioner. The Senior Practitioner has prepared the Individual Development Plan which outlines the provision of programs and services that best promote the care, support and rehabilitation of each individual client.

4.1 IDP reviews

IDP reviews must consider current risk factors for clients and how rehabilitative programs and support approaches are addressing identified dynamic risk factors. The reviews should also consider any barriers to reducing risk and identify approaches to addressing these barriers. Reviews should consider how the client has progressed in programs, activities and LCT and developed relevant skills and pro-social behaviour. Furthermore, reviews should consider whether risk management plans are adequately mitigating risk in the least restrictive way. Reviews should determine whether further risk assessment is required.

Where risk management strategies have changed updates should be made to the IDP so that risk management strategies remain current and are clear for staff to follow.

5. Limited Community Treatment (LCT)

Prior to a client visiting or attending a new LCT location in the community, a venue risk assessment must be undertaken. The venue risk assessment must take into account the client's known risk factors, as informed by evidence based risk assessments. The assessment may involve visiting the venue or undertaking research to identify any variables and potential risks that may arise, taking into consideration the individual's risk profile. Where risk factors have been identified, a venue may still be considered suitable where appropriate strategies can be implemented to mitigate any identified risks.

The Senior Practitioner should review venue risk assessments and risk management plans in order to approve the LCT plan (refer to *Director of Forensic Disability Policy - Community Treatment and Other Leave*).

The staff member (FDS or external service provider) who escorts/supervises a client on LCT must document progress or any issues of concern in relation to the LCT event and these records should inform regular reviews and updates of the client's IDP and risk management plans. This evidence should also support recommendations made to the MHRT regarding LCT.

6. Daily clinical risk judgements and management

Staff should conduct daily dynamic risk assessments and record all relevant information pertaining to risk. A dynamic risk assessment should also be undertaken prior to a client accessing LCT, undertaking a new activity where the risks are unknown, or undertaking an activity that has known risks to the client or the safety of others. Dynamic risk assessment should consider the client's base line risk, pattern of behaviour escalation, and any risk factors that may be unique to them.

Results of the assessment should inform strategies of support for any proposed activity or LCT. Results will also provide evidence to determine if the activity/event should proceed. Where significant risk is identified, the Senior Practitioner should be notified to discuss appropriate risk management strategies (such as increased staffing) or provide a recommendation to postpone or cancel the activity or LCT (refer to *Director Forensic Disability Policy – Community Treatment and Other Leave*).

Staff must ensure presenting risks and approaches to managing the risk is documented in case notes in FDAIS and any relevant behaviour recording. This will ensure information is communicated across shifts and staff have a clear understanding as to how best to support the client. Information recorded should include any risk relevant factors and decisions that have been made (e.g. cancellation of planned activity, current stressors/potential triggers for client, any decisions related to limiting access to area of unit or items; concerns re interactions with staff or other clients; and recommended observation levels).

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Attachment 1

A.1 Static risk

Static risk factors usually do not change and are not amenable to targeted interventions or management strategies. Understanding static risk factors is, however, important as it provides a clinical measurement of the long–term level of risk of recidivism and a clinical gauge as to the appropriate intensity and duration of criminogenic interventions and supervision required for each client.

Static risk assessments may include, but are not limited to:

- Historical Clinical Risk – 20 Version 3 (HCR-20)***;**
- Violence Risk Appraisal Guide (VRAG);
- Sex Offender Risk Appraisal Guide (SORAG);
- STATIC 99R;
- Sexual Violence Risk – 20 (SVR-20)***;**
- The Level of Service Inventory – Revised (LSI-R)***;**
- The Risk for Sexual Violence Protocol (RSVP)*; and
- Structured Assessment of Protective Factors for Violence Risk (SAPROF)***.**

* Note: risk assessment includes both dynamic and static risk factors

A.2 Dynamic risk

Dynamic risk factors have the potential to change and are amenable to intervention. Some dynamic factors may change more rapidly and frequently than others and can be described as stable or acute. Dynamic risk assessment can include assessment of:

- Stable Dynamic Risk – to identify dynamic risk and protective factors that can be targeted in programs, are likely to change slowly over time and can be used to gauge change.
- Acute Dynamic risk – to identify risk factors capable of changing abruptly and frequently to inform risk management strategies and immediate decisions regarding support models and plans.

Dynamic risk assessments may include, but are not limited to

- Dynamic Risk Assessment Management System (DRAMS);
- Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend – Sexually (ARMIDILO-S);
- Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend – General Version (ARMIDILO-G);
- STABLE – 2007;
- ACUTE – 2007;
- Historical Clinical Risk – 20 Version 3 (HCR-20)***;**
- Sexual Violence Risk – 20 (SVR-20)***;**
- The Level of Service Inventory – Revised (LSI-R)***;**
- The Risk for Sexual Violence Protocol (RSVP)*; and
- Structured Assessment of Protective Factors for Violence Risk (SAPROF)*****.

* Note: risk assessment includes both dynamic and static risk factors

A.3 Assessments related to specific offending

Further assessments may be undertaken to understand risk factors and treatment needs in relation to particular offences and may include but are not limited to:

Sexual offending

- Questionnaire on Attitudes Consistent with Sexual Offenders (QACSO);
- Assessment of Sexual Knowledge (ASK);
- Sexual Attitudes and Knowledge (SAKS); and
- Victim Empathy Scale – Adapted.

Fire-setting

- Fire Setting Attitudes Scale (FSAS); and
- Fire Interest Rating Scale.

Physical assault

- Novaco Anger Scale;
- Novaco Anger Scale – Provocation Inventory (NAS-PI); and
- Dundee Provocation Inventory.