Justice Health and
Forensic Mental Health Network

Justice Health NSW Procedure

Clinical Risk Assessment and Management (CRAM)

Framework and Documentation

Issue Date: November 2025

Together for Healthier Tomorrows

Clinical Risk Assessment and Management (CRAM) – Framework and Documentation

Procedure Number 6.100

Procedure Function Continuum of Care

Issue Date November 2025

Next Review Date Extreme 2027

Risk Rating Extreme

Summary This procedure guides staff in the 'enquire, identify, formulate, manage and review' phases of the CRAM Framework. This procedure must be implemented in conjunction with Policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review*, Clinical Risk Assessment and Management – A Practical Guide for Mental Health Clinicians and mandatory FH CRAM Training.

Responsible Officer Service Director Forensic Hospital

Applies to
☐ Administration Centres
☐ Community Sites and programs
☐ Health Centres - Adult Correctional Centres or Police Cells
☐ Health Centres - Youth Justice Centres
☐ Long Bay Hospital
☒ Forensic Hospital

CM Reference PROJH/6100

Change summary Addendum for short stay patients incorporated into main body of procedure. Addition of discipline responsibilities for HCR-20. Addition of CRAM Flowchart. Procedure reworded and restructured for clarity.

Authorised by Forensic Hospital Policies, Procedures and Guidelines Committee

Revision History

#	Issue Date	Number and Name	Change Summary
1	July 2018	DG21887/17	-
2	February 2022	DG529/21	DG76405/23
3	October 2023	DG76405/23	DG76405/23
4	November 2025	DG67917/25	DG67920/25

Justice Health and Forensic Mental Health Network
PO BOX 150 Matraville NSW 2036
Tel (02) 9700 3000
http://www.justicehealth.nsw.gov.au

1. Table of Contents

2. Preface

The Clinical Risk Assessment and Management (CRAM) Framework is an evidence-based guide designed to assist clinicians in identifying, formulating, and managing the risk of violence. It supports the safe delivery of care within the Forensic Hospital (FH), informs treatment, and guides the safe transition of patients to less secure care settings.

This procedure provides guidance on CRAM processes and documentation requirements for clinical staff in the Forensic Hospital and must be implemented in conjunction with Policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review*, Clinical Risk Assessment and Management – A Practical Guide for Mental Health Clinicians and mandatory FH CRAM Training. While CRAM is primarily focused on the risk of violence, it can also be applied to manage any other risks identified for an individual patient.

3. Procedure Content

CRAM components and process

Risk Assessment

3.1 Historical Clinical Risk Management-20 Version 3 (HCR-20v3)

1. The HCR-20v3 is a 20-item structured clinical judgement tool which guides the assessment, formulation and management of violence risk in adults.
2. The HCR-20v3 is completed for all adult patients in the Forensic Hospital. Assessments should follow the guidelines in the manual, which is available on each ward, along with information provided in mandatory CRAM training and the Justice Health NSW HCR-20 training.
3. The assessment commences at admission. C items are to be prioritised and should be completed by the first MDT review. The full HCR-20 should be completed, and assessment finalised within JHeHS within the first three months of admission.
4. For short-stay correctional or civil patients (e.g. those admitted to Freshwater Unit or a ring-fenced bed), C items are prioritised and must be completed. H and R items may be completed if information is available and deemed appropriate by MDT within anticipated admission timeframe. The assessment will remain 'open' on JHeHS for the duration of admission but must be finalised at discharge. For those items that remain incomplete at time of finalisation, it should be indicated in the text box that the item was not completed due to it being an interim assessment for a short-stay patient.
5. The HCR-20 will be reviewed and updated at a minimum every six months, by the Multidisciplinary Team (MDT) at the in-depth case review completed prior to Mental Health Review Tribunal hearings. The update must be finalised in JHeHS.
6. C items must be reviewed/updated to support leave applications, SCALE changes, referral/acceptance to Mana Yura programs, if there has been an aggressive incident, or if there have been any other changes to presentation or risk.
7. Identified risks factors will be used to complete the risk formulation section in the HCR-20 JHeHS form. Any risks identified must be documented in the patient's TPRIM and a management/intervention plan created to mitigate those risks.

8. Discipline responsibilities regarding HCR-20 completion/updates are outlined in appendix 6.1. Note, any item/task can be completed by any discipline, however the named discipline has responsibility for ensuring that item/task is completed.

3.2 Structured Assessment of Violence Risk in Youth (SAVRY)

1. The SAVRY is a 24-item structured clinical judgement tool which is used to assess and manage the risk of violence in young people (12-18 years)
2. The SAVRY must be completed as per manualised instructions, for all young people admitted to the Forensic Hospital.
3. The SAVRY must be saved into JHeHS and linked to the patients CRAM eForm in the relevant section as per appendix 6.2.
4. The assessment is allocated by the MDT at admission and is generally completed by the Psychiatric Registrar and another member of the MDT.
5. The SAVRY will be reviewed and updated by the MDT at a minimum of every six months, at the in-depth case review completed prior to Mental Health Review Tribunal hearings.
6. Assessments must be reviewed/updated to support leave applications, SCALE changes, referral/acceptance to Mana Yura programs, if there has been an aggressive incident, or if there have been any other changes to presentation or risk.
7. Any risks identified must be documented in the patient's TPRIM and a management/intervention plan created to mitigate those risks.

3.3 Dynamic Appraisal of Situational Aggression (DASA)

1. The DASA is a brief, observer-rated tool that assesses risk of imminent inpatient aggression. Adult patients must be scored using the DASA, and adolescent patients must be scored using the DASA Youth Version.
2. DASA scoring must be carried out according to the manual. DASA manuals are available on each unit, and guidance is provided through mandatory CRAM training.
3. Starting at admission, the DASA will be completed daily between 1230-1330hrs by each patient's allocated nurse in the DASA eForm in JHeHS. DASA scores must also be documented in JHeHS Progress Notes and handed over to the oncoming shift.
4. If any DASA items are scored as 'present', interventions must be initiated to assist in the prevention of further escalation.
5. The MDT may decide to discontinue daily DASA scoring based on their clinical risk assessment. This decision should be recorded in the patient's TPRIM (monitoring section). If the patient's clinical condition or presentation changes, the MDT can resume DASA scoring at any point during the patient's admission if deemed necessary.

3.4 Other Validated Assessments

1. Other validated assessments may form part of CRAM to provide a more comprehensive picture of a person's risk. Thes may include tools that assess risk of specific problem behaviours (e.g. problem sexual behaviours, stalking, domestic violence), responsivity (e.g. assessments of psychopathy, personality, neurocognitive assessments), and those that identify protective factors.
2. Assessment reports must be saved into JHeHS and linked to the patients CRAM eForm in the relevant section.

3.5 Anamnestic Assessment

1. Anamnestic assessment involves examining prior incidents of aggression in order to identify common factors and patterns. This allows clinicians to develop an anamnestic formulation which will inform risk management.
2. Patient files and documentation must be reviewed prior to the first in depth case review to identify previous incidents of aggression. These should be added to the Anamnestic Incident Summary Template saved in the patient's folder in the G:Drive, and scanned into JHeHS under 'observations and assessments' – 'risk assessment'. See appendix 6.4 for a guide on how to scan documents into JHeHS.
3. For short-stay patients where a review of all previous aggressive incidents may not be feasible, anamnestic assessment can occur based on a review of incidents that occur during admission. Previous incidents can be included if information is available and deemed appropriate by the MDT within anticipated admission timeframe.
4. All incidents of aggression in the Forensic Hospital will be documented contemporaneously in the JHeHS patient's progress notes selecting '5W' as the note type. No further progress notes are required for the incident as all details should be incorporated into the 5W. See appendix 6.5 for a 5W documentation guide.
5. The Anamnestic Incident Summary and all incidents documented in 5W format will be reviewed by the MDT prior to an in-depth case review to identify any common factors related to aggression. This may include a functional analysis of aggressive behaviour completed by the clinical/forensic psychologist.
6. The anamnestic formulation, developed by the MDT, must be documented in the CRAM eform and be used to inform management strategies to mitigate risk.

Risk Management

3.6 Treatment and Management Plan (TPRIM)

1. The TPRIM is a clinical document which outlines the identified risks, the treatment and management of the patient. It encompassed the following domains:
   a) **T**reatment
   b) **P**lacement
   c) **R**estrictions
   d) **I**mplementation
   e) **M**onitoring
2. The TPRIM eform in JHeHS must be completed for each patient. The TPRIM Tip Sheet can be used to assist completion.
3. The TPRIM will capture all aspects of patient care, including but not exclusive to the risk of violence and the management strategies in place to mitigate the risks. This will allow early intervention and implementation of management strategies should Early Warning Signs (EWS), triggers or risks be identified.
4. The TPRIM is to be completed pre-admission, and updated at admission, patient reviews, MDT Meetings (at least fortnightly for acute units and at least monthly for sub-acute/rehab units), in-depth case reviews or as often as clinically indicated.
5. It is an expectation that clinicians review the TPRIM each shift. If staff are unfamiliar with the patient or have any concerns regarding safety, this must be escalated to the nurse in-charge or Nurse Unit Manager.

3.7 Safety Plan

1. The Safety Plan is an individualised and person-centred plan which assists a patient to draw on their strengths when attempting to manage self-harm, violence and recurring problematic behaviour.
2. A Safety Plan form (JUS060.850) must be completed on admission by the Care Coordinator (CC) or delegate, in collaboration with the patient.
3. The Safety Plan must be renewed at least every 6 months but should be reviewed after any significant incident.
4. Information from the Safety Plan should be incorporated into the patient's TPRIM and used to inform management strategies.
5. A copy of the completed and signed Safety Plan should be given to the patient and filed into the patient's paper health record.
6. Any previous Safety Plans will be removed from the health record and archived by the Ward Clerk.

3.8 Care Plan

1. The Care Plan (SMR060.500) is an individualised, person-centred plan which identifies areas of development for a patient. The plan, developed collaboratively between the patient and the MDT, is a supporting document to the TPRIM, and can be retained by the patient as a point of reference.
2. The Care Plan must be developed with the patient and led by the Care Coordinator (CC) or delegate. It must then be reviewed at least every 6 months but can be updated if goals or clinical issues change.
3. A copy of the completed and signed Care Plan should be given to the patient and filed into the patient's paper health record.
4. Any previous Care Plans will be removed from the health record and archived by the Ward Clerk.

3.9 Clinical Risk Assessment and Management eForm (CRAM eForm)

1. The CRAM eForm brings together the components of CRAM into an overarching summary of risk assessment, formulation and management in JHeHS.
2. The CRAM eForm must be completed for all patients in the FH with the exception of short-stay correctional/civil patients (e.g. those admitted to Freshwater Unit or a ring-fenced bed)
3. The CRAM eForm Tip Sheet can be used to assist completion.
4. The CRAM eForm must be initially completed in time for the patient's first in-depth review/MHRT and should be updated at least every six (6) months in preparation for the patient's MHRT.

3.10 Dangerousness, Understanding, Recovery and Urgency Manual (DUNDRUM) Quartet

1. The DUNDRUM is a set of structured professional judgement instruments that assist decision making about admission, transfer and discharge in forensic mental health settings. The components of DUNDRUM used in the FH measure activities delivered to reduce risk and aid recovery.

2. The DUNDRUM is used for all adult patients in the Forensic Hospital with the exception of short-stay correctional/civil patients (e.g. those admitted to Freshwater Unit or a ring-fenced bed).
3. The DUNDRUM must be used as per The DUNDRUM Toolkit and completed in JHeHS.
4. The DUNDRUM 1, 3 and 4 assessments will be completed by the MDT at the initial in-depth case review and 3 and 4 reviewed at each subsequent in-depth review.

CRAM Procedure and Timeframes (appendix 6.6)

3.11 Pre-Admission

1. The MDT will request the following information from the referrer upon receiving a referral. This information must be saved in the individual patient folder in the G:Drive and reviewed by the MDT to develop an initial TPRIM in JHeHS:
   a) Progress notes and medication charts for the past six (6) months
   b) Urine Drug Screen (UDS) completion and results
   c) Previous MHRT reports
   d) Allied Health handover and/or related documentation
   e) OIMS Inmate Profile and other case notes
   f) CYMS – Youth Justice database information
   g) NSW Police Criminal Record
   h) Original judgment and court records regarding unlawful act(s)
2. An MDT assessment (including representation from both medical and nursing at a minimum) of the patient must be completed prior to transfer. The assessment must include but is not limited to:
   a) Assessment of mental state
   b) Current challenges
   c) Drug history and current use
   d) Preliminary risk assessment (looking at contextual factors and risk management needs)
   e) an explanation of the Forensic Hospital environment including the procedure on admission
   f) clarification of family or significant other support
   g) assessment of the patient's attitude to admission

3.12 On Admission

1. Admitting staff must commence admission processes as described in Procedure 6.203 *Referral, Admission and Transfer of Care*.
2. The initial TPRIM developed on pre-admission will be updated after the admission assessment. The Allocated Nurse or other MDT member will update this document.
3. A DASA must be commenced and completed by the Allocated Nurse each shift/day until the MDT directs that it can be ceased.
4. A Safety Plan and Care Plan should be completed with the patient.
5. A HCR-20/SAVRY must be commenced prior to the first MDT, prioritising clinical (C) factors. Discipline responsibilities outlined in appendix 6.1.

6. For short-stay patients (e.g. those admitted to Freshwater Unit or a ring-fenced bed), an interim HCR20v3 must be completed as close as possible to admission to the FH, either following acceptance but prior to admission, or within 3 working days of admission. At a minimum, (C) factors should be completed, with (H) items completed if evidence is available and if possible, within timeframe (as determined by MDT). (R) items should be completed if relevant and if evidence is available. This form should remain in interim on JHeHS until the patient has been discharged, at which point it should be finalised.
7. For short-stay patients, an anamnestic assessment must be completed as soon as possible post admission as per section 3.5. Information on any previous incidents of aggression, particularly those that have occurred in the context of a patient's current behavioural presentation and setting, should be added to the Anamnestic Incident Summary Template saved in the individual patients appropriate folder in the G:Drive. The anamnestic formulation should be completed in the CRAM eForm. If the short time frame for admission does not permit a full review of previous incidents, the assessment can be completed based on incidents during admission.

3.13 First Six Months of Admission (excluding short-stay patients)

1. A comprehensive documentation review will be completed by the Consultant Psychiatrist and Psychiatry Registrar with support from the Clinical/Forensic Psychologist and CC. The Consultant Psychiatrist will delegate relevant clinicians to liaise with identified sources of information to gather collateral information.
2. This review will inform the completion of the full HCR-20/SAVRY (discipline responsibilities outlined in appendix 6.1) and anamnestic assessment (to be completed by the Clinical/Forensic Psychologist or delegate), within the first 3 months of admission.
3. CRAM documentation will be prepared as outlined in section 3.14 for the first In-Depth Case Review.

3.14 In-Depth Case Review (excluding short-stay patients)

1. The In-Depth Case Review will be completed 6 weeks prior to the patients MHRT Hearing date. Adolescents may have a shorter timeframe.
2. The MDT will review and update the following at a minimum:
   a) MHRT report
   b) CRAM eform – inclusive of Risk formulation(s)
   c) HCR-20/SAVRY
   d) Anamnestic assessment
   e) DUNDRUM (1, 3 and 4 at initial in-depth case review, and 3 and 4 at subsequent – Adult patients only)
   f) Safety Plan and Care Plan
   g) Other Relevant Assessments

3.15 Continuing Care

1. DASA is to be continued daily as per section 3.3.
2. TPRIM is to be updated at ward round/MDT review or with any change to plan/management.
3. HCR-20/SAVRY Clinical items to be reviewed/updated to support leave applications, SCALE changes, referral/acceptance to Mana Yura programs, if there has been an aggressive incident, or if there have been any other changes to presentation or risk.

3.16 Referral and Transfer of Care

1. When a patient is referred or transferred to another unit within the Forensic Hospital, the MDT will ensure the following are up to date:
   a) TPRIM
   b) CRAM eForm
   c) HCR-20/SAVRY
   d) DUNDRUM (3 and 4 – adult patients only)
   e) Anamnestic assessment
   f) Safety Plan and Care Plan
2. When a patient is discharged from the FH:
   a) all interim CRAM documents on JHeHS must be finalised.
   b) If appropriate, CRAM documentation may be handed over to the receiving service.

4 Definitions

Must

Indicates a mandatory action to be complied with

Should

Indicates a recommended action to be complied with unless there are sound reasons for

5 Related documents

Legislations	
Justice Health NSW Policies, Guidelines and Procedures	Policy 1.075 *Clinical Handover* Policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review Forensic Hospital* Policy 1.319 *Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit* Procedure 6.138 *Recognition and Management of Patients who are Deteriorating* Procedure 6.203 *Referral, Admission and Transfer of Care* Guideline 6.132 *Forensic Hospital Referrals (Custodial and Civil Patients)*
Justice Health NSW Forms	Paper Forms: JUS060.850 Safety Plan, SMR060.500 Care Plan eForms: CRAM, HCR-20, DUNDRUM, TPRIM, DASA
NSW Health Policy Directives and Guidelines	PD 2019_020 *Clinical Handover*

Other documents and resources	Clinical Risk Assessment and Management – A Practical Guide for Mental Health Clinicians

6 Appendix

6.1 HCR-20v3 Discipline Responsibilities

Item completion/Task	Discipline Responsible*
History of Problems With…	
H1 Violence	Psychology
H2 Other Antisocial Behaviour	Psychology
H3 Relationships	Social Work
H4 Employment	Occupational Therapy
H5 Substance Use	Medical
H6 Major Mental Disorder	Medical
H7 Personality Disorder	Medical
H8 Traumatic Experiences	Social Work
H9 Violent Attitudes	Psychology
H10 Tx/Supervision Response (Past)	Occupational Therapy
Recent Problems With…	
C1 Insight	Psychology
C2 Violent Ideation or Intent	Psychology
C3 Symptoms of Major Mental Disorder	Medical
C4 Instability	Medical
C5 Tx/Supervision Response (Recent)	Occupational Therapy
Future Problems With…	
R1 Professional Services and Plans	Social Work
R2 Living Situation	Social Work
R3 Personal Support	Social Work
R4 Tx/Supervision Response (future)	Occupational Therapy
R5 Stress or Coping	Medical
Other	
Future Violence Case Prioritisation	Medical/Psychology
Risk Formulation	Medical/Psychology
HCR-20 Finalisation in JHeHS	Medical/Psychology
Delegating tasks/responsibilities in absence of MDT member	Medical

* NB Completion of task may be delegated to another discipline, however listed discipline has responsibility to ensure that task is completed

6.2 CRAM Tasks and Responsible Clinicians – Standard Admission

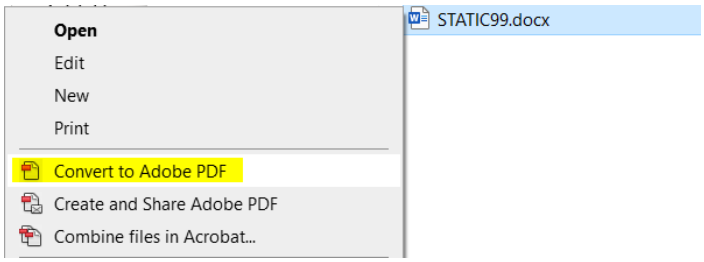
Assessment Period	CRAM Tasks		Lead Clinician/Discipline
Pre-Admission	TPRIM developed from available information		CC/Nursing
On admission	TPRIM reviewed and updated with admitting information		Nursing
	DASA commenced		Nursing
	Safety Plan commenced		CC/Nursing
Regular MDTs	Review and Update TPRIM		MDT
	Review and Update Safety Plan		MDT
	Review and Update Care Plan		MDT
Prior to In-Depth Case Review	**Initial**	**Subsequent**	
	Complete Comprehensive Clinical Review	Ongoing	Medical
	Complete Documentation Review	Documentation Review from last 6 months	Medical/Psychology
	Complete Corroborating Information	Ongoing	MDT – delegated by Consultant
	Complete Anamnestic Incident Summary and Assessment	Revise Anamnestic Assessment from last 6 months 5Ws	Psychology
In-Depth Case Review	**Initial**	**Subsequent**	
	Complete MHRT Report	Update MHRT Report	Medical with input from MDT
	Complete CRAM eForm	Update CRAM eForm	CC
	Complete HCR-20 / SAVRY	Update HCR-20 / SAVRY	Medical/Psychology – MDT input as at 6.1
	Complete DUNDRUM 1, 3 and 4	Update DUNDRUM 3 and 4	Medical
	Incorporate Anamnestic Factors into Risk Assessment/ Formulation	Update Anamnestic Factors and Risk Formulation	Medical/Psychology
Inter-Ward Referral and Transfer	**Ensure following up to date:**		
	CRAM eForm		CC
	HCR-20 / SAVRY		Psychology
	DUNDRUM 3 and 4		Medical
	Safety Plan and Care Plan		CC
	Anamnestic Assessment		Psychology
	TPRIM		CC
Discharge	Finalise all interim CRAM documents in JHEHS		CC or delegate
	CRAM handover		Medical

6.3 CRAM Tasks and Responsible Clinicians – Short-Stay Admission

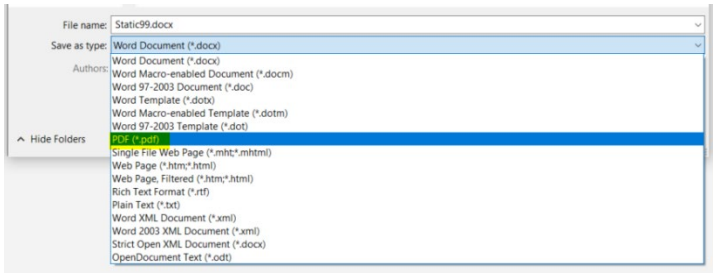
Assessment Period	CRAM Tasks	Lead Discipline
Pre-Admission	Commence interim HCR20v3	Psychology/Medical
	Commence TPRIM	Nursing
Admission	Complete interim HCR20v3 and update as required	Psychology/Medical
	Update TPRIM with admitting information and update as required	Nursing
	Commence DASA	Nursing
	Complete Safety Plan with patient	Nursing
	Anamnestic incident summary	Nursing
	Anamnestic assessment	Psychology
Discharge	CRAM handover	Medical

6.4 Scanning Documents into JHeHS

1. Convert document into a PDF if not already one by right clicking the document and selecting "*Convert to Adobe PDF*".

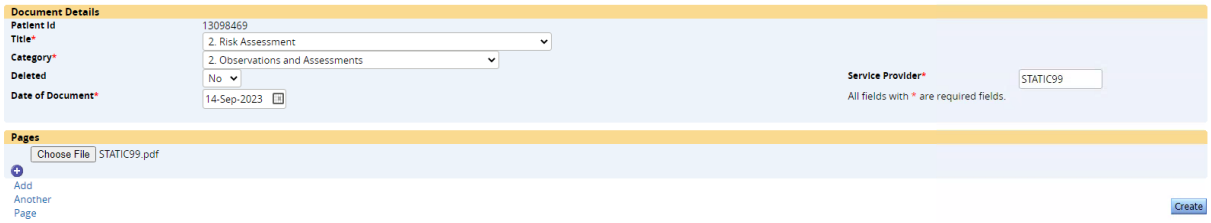


2. You can also convert the document into a PDF by using the "*Save As*" function and selecting "*PDF*" from the drop down.

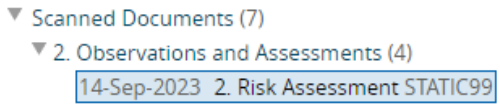


3. Find the required patient in JHeHS and select "*Add New scanned Document*".
4. Select the appropriate "*Category*" and "*Title*" based on the Scanning Categories Lists of Scanned Documents in JHeHS and complete "*Date of Document*".
5. In the "*Service Provider*" field type the name of the Risk Assessment or Document you will be uploading.
6. Upload the required PDF by selecting "*Choose File*" then select "*Create*" to finalise.

Example Upload:



7. The document should then appear in the appropriate "*Scanned Documents*" "*Category*" based on your selections above, with the name visible by what you typed in the "*Service Provider*" field.



8. This document can then be linked to the CRAM eForm as per the CRAM eForm Tip Sheet.

6.5 5W Approach – Documentation Tip sheet

All incidents of aggression in the FH must be documented in detail using the 5W approach in the patient's health record. The 5W note type should be selected in JHeHS progress notes. No other entry is required.

When the incident occurred	Date and time
Where it occurred	Unit and area, grounds, rec hall, room number
Who the victim(s) were (role, age, sex and relationship)	Who was the aggressive incident directed towards. Be specific, age, gender, discipline, relationship to patient.
What behaviour they engaged in and what the consequences were	Describe what was happening: • Prior to the incident (Antecedents) • During the incident (Behaviour) • Post incident (Consequence)
Why they engaged in the behaviour	• The patient's reason for the incident • Your opinion of why the incident occurred. Document using phrases such as 'Incident appears to have occurred as the result/ in response to/……..' • Consider if the following factors may have influenced the incident: ▪ The patient's experience - e.g. MI symptoms, fear, frustration, exposure to triggers etc. ▪ The unit – e.g. the ward dynamics of the ward, interactions with peers, busyness, patient mix.

	▪ The patient's outside world – the impact of visits, family worries, family illness etc. ▪ And Team issues – unfamiliar staff, unclear rules, boundaries, consistency etc.

6.6 Forensic Hospital CRAM Flowchart