DMH POLICY

Title: Inpatient Clinical Risk (ICR) Screening, Assessment, Consultation And Review	**Policy #: 21-02** **Date Issued: November 1, 2021** **Effective Date: December 6, 2021**
Approval by Commissioner: Brooke Doyle **Signature: Brooke Doyle, M.Ed., LMHC**	**Last Reviewed: November 1, 2021**

I. PURPOSE

Formal risk assessment in Department of Mental Health (DMH)-operated and contracted Facilities is a critical element of treatment and discharge planning. Early identification of a Patient's risks and strengths, and specialized consultation as needed, facilitate the ability of the Treatment Team, the Patient/LAR[1], and, as applicable, community providers, to develop timely and effective strategies for treatment, risk mitigation, and discharge planning. Ultimately, this collaborative effort aims to shorten hospital stays, increase community access and tenure, and enhance recovery, while taking into consideration the safety of the Patient and the public.

This policy establishes the processes and associated documentation requirements for identifying and assessing risks and strengths upon a Patient's admission to a Facility and for the ongoing risk assessments, consultations and risk reviews that occur during the hospitalization to mitigate risk and to prepare for the person's discharge. These processes are intended to inform and augment, but not to replace the Patient's individual inpatient treatment planning. To the fullest extent possible, the risk screening, assessment and review processes are conducted collaboratively among the Patient, Treatment Team and consultants.

This policy replaces and repeals DMH Policy #12-02, Inpatient Enhanced Clinical Review.

[1] Throughout this policy, references to collaboration with and/or involvement of, the Patient in planning and risk review activities shall include, where appropriate, the Patient's family and/or legally authorized representative (LAR).

II. SCOPE

This policy applies to DMH-operated and contracted inpatient continuing care Facilities, including the two adolescent continuing care inpatient units at Worcester Recovery Center and Hospital (WRCH). DMH-operated or contracted acute care units, and certain acute care admissions to DMH Deaf Inpatient Services beds, are not subject to this policy.

III. DEFINITIONS

Area Medical Director (AMD): The senior psychiatrist responsible for clinical oversight of DMH clients and services in a particular DMH Area.

Area Medical Director (AMD) Risk Review: A risk assessment consultation provided by the Area Medical Director, mandatory or elective, as outlined in this policy.

Central Office Risk Review: A risk assessment consultation provided by the DMH Assistant Commissioner for Forensic Services and/or DMH Deputy Commissioner for Clinical and Professional Services or designees, mandatory or elective, as outlined in this policy.

CORI: Criminal Offender Record Information maintained by the Department of Criminal Justice Information Systems (DCJIS).

Days: Sunday through Saturday, including legal holidays.

Facility: A DMH continuing care inpatient hospital contracted for or operated by DMH, including DMH operated units in Department of Public Health facilities and DMH adolescent continuing care inpatient units.

Facility Medical Director (FMD): The senior psychiatrist responsible for the clinical and administrative supervision of Psychiatric Attendings, and the clinical oversight of care provided in a DMH-operated or contracted inpatient Facility.

Facility Medical Director (FMD) Risk Review: A risk assessment consultation to a Patient's Treatment Team provided by the Facility Medical Director, or designee, as outlined in this policy.

Inpatient Clinical Risk (ICR) Clinician: As used in this policy, independently licensed clinical staff who have specific risk assessment competencies and risk assessment privileges as determined by Facility specific privileging standards and the DMH Office of Inpatient Management.

Independent Forensic Risk Assessment (IFRA): An evaluation to inform decisions regarding community access and discharge completed pursuant to the DMH Independent Forensic Risk Assessment Policy.

Lamb Warning/Limits of Confidentiality: A notification given to a Patient by clinicians, prior to an evaluation, that the Patient's participation is voluntary and may be terminated at any time, and that any communications made during the course of the evaluation will not be privileged and may be disclosed in court proceedings. A Lamb Warning is only valid if the Patient knowingly and voluntarily agrees to waive the privilege upon receiving such notification.

Legally Authorized Representative (LAR): A guardian or other fiduciary granted applicable authority by a court of competent jurisdiction or, in the case of a minor, the parent(s) or other individual or entity with legal custody of the minor. For the purpose of this policy, the term "LAR" is limited to those LARs who are authorized to make health care decisions.

Off-grounds Access: Access to the community outside the boundary limits of the hospital grounds, with or without supervision by hospital staff.

Office of Inpatient Management (OIM): The office established by the DMH Commissioner that is charged with working with Facility operational and clinical leadership to identify, develop, implement, maintain, and review protocols for the DMH inpatient system to meet, regulatory, policy, CMS, and Joint Commission standards.

Patient: As used in this policy, the term Patient refers to a person hospitalized in a Facility pursuant to M.G.L. c.123, except persons admitted pursuant to M.G.L.c. 123, s. 18 (a) pre-arraignment.

Psychiatric Attending: The Psychiatrist, Psychiatric Nurse Practitioner, Psychiatric Clinical Nurse Specialist, or Psychiatric Physician's Assistant with primary responsibility for the Patient's treatment.

Risk Domains: The Risk Domains to which this policy pertains including Violence to others, Problematic Sexual Behavior, Fire Setting, Substance Use, and Suicide.

Risk Assessment Summary (RAS): A risk assessment summary tool that is used to collect and synthesize risk related data obtained during the admission assessment process and throughout the inpatient stay in order to inform treatment and safety planning and to determine whether or not additional, more in-depth specialized risk assessment(s) are necessary to inform risk mitigation efforts and discharge planning.

Risk Review Referral Packet: Information submitted to the FMD, or the AMD to initiate the FMD Risk Review or AMD Risk Review process. Minimally, this packet includes the RAS, the Team Risk Review documents, any applicable Specialized Risk Assessments, and, if applicable, any IFRA review.

Sex Offender Registry Board (SORB): The Massachusetts state government board that registers and classifies convicted sex offenders according to their risk of re-offense and degree of danger they pose, and provides public access to information about higher-risk sex offenders in order to prevent further victimization.

Specialized Risk Assessment (SRA): A report of the assessment and recommendations based on the integration of evidence based and evidence informed dynamic and static variables in a specific Risk Domain provided by or supervised by ICR Clinicians.

Team Risk Review: A review and recommendations by a Patient's Treatment Team of a Patient's potential behavioral risks, and risk assessment and mitigation needs, conducted at specified intervals in accordance with this policy.

Treatment Team: The interdisciplinary clinical team providing and directly overseeing the care and treatment of a Patient.

Treatment Plan: A Patient's individual treatment and recovery plan developed by the Treatment Team in collaboration with the Patient.

Unsupervised Access: A Patient's access to open, unsecured areas of the Facility, or access to the community, without being supervised by hospital staff.

IV. POLICY

A. Overview

A Patient's risk of harm to themselves and/or others should be mitigated through processes of careful on-going risk screening, assessment, consultation, treatment and risk mitigation planning that are documented in the Patient's medical record. All Patients admitted to DMH facilities, including persons who are committed for observation and examination, are initially screened and assessed for risk through routine admission assessment processes. Information relevant to risk is collected and reviewed throughout a person's admission and organized in the Risk Assessment Summary (RAS). The RAS is updated as new information relevant to the need for Specialized Risk Assessments is obtained over the course of the inpatient stay. Information collated in the RAS informs treatment and safety planning, and the identification of specific Risk Domains that may require further Specialized Risk Assessments (SRAs). Inpatient Clinical Risk (ICR) Clinicians conduct or supervise completion of SRAs. Treatment Teams led by a Psychiatric Attending are responsible to incorporate related treatment and risk mitigation recommendations into the Patient's Treatment Plan and discharge plans. Treatment Teams are further responsible to conduct and document Team Risk Reviews prior to initially providing the Patient with Off-grounds Access, Unsupervised Access, and/or submission of a M.G.L. 123, s.16(e) 30-day notice of Intent to Discharge, or discharge.

In certain instances, defined herein (see Section IV.I.2), the Treatment Team is required to provide a Risk Review Referral Packet to the FMD for review. FMDs, and in some cases AMDs, are responsible to provide Risk Review consultation or may request a Risk Review under specific circumstances related to the authorization of Off-grounds Access, Unsupervised Access, submission of a 16(e) 30-day notice of Intent to Discharge, or discharge. Such reviews shall occur collaboratively among team members and their consultants, including but not limited to ICR clinicians and IFRA consultants.

B. Facility Protocols

Each Facility shall develop and maintain protocols that are consistent with and support the implementation of this policy. Such protocols will include and be consistent with the OIM-approved processes, assessments, and forms referenced in this policy.

C. Patient Participation in Risk Screening, Assessment and Review Processes

1. The Patient shall be informed by the Psychiatric Attending and other members of the Treatment Team about how risk screening, assessment and review processes relate to them, in support of treatment and discharge planning that reduces the risk of harm to the Patient or others.

2. As with all other clinical assessments, the ICR Clinician conducting a SRA reviews the limits of confidentiality, (e.g. the Lamb Warning), where appropriate, with the Patient. The Patient shall be informed of their right to consult with a Human Rights Officer or seek support from a Peer Specialist or other person(s) of their choosing.

3. As part of the admission assessment, RAS and SRA processes, Patients or LARs may be asked to authorize the release of relevant information from other sources that are not within the DMH record (e.g. past evaluations, knowledgeable third parties, CORI systems from other states). In the event that authorizations are not signed, the Patient and LAR shall be informed that risk assessment will proceed on the basis of available information.

4. The Patient may decline to participate in SRA interviews or in answering particular interview questions; in those instances risk assessments may proceed without direct input from the Patient.

D. Records, Reports, and Documents Obtained Through Risk Screening Processes

1. Each Facility must have a protocol that establishes procedures for obtaining and tracking relevant records for completion of the RAS and SRAs. Relevant records

shall include the DMH approved list of standard documents to be sought for purposes of risk assessment.

2. A standard documentation set is required for referrals for FMD and AMD reviews and any necessary reviews by the Deputy Commissioner for Clinical and Professional Services and Assistant Commissioner for Forensic Services. The documentation set must include a list of documents sought and indicate whether they were obtained or unavailable.

E. Risk Assessment Summary (RAS)

1. The RAS must be completed for all Patients admitted to Facilities, including persons committed for observation and examination, for the purposes of:
   a. Identifying/inventorying risks that must be addressed in treatment and discharge planning; and
   b. Determining whether any of the following are required:
      i. One or more of the SRAs
      ii. An Independent Forensic Risk Assessment (IFRA).

2. The RAS must be completed by an ICR Clinician or a clinician supervised by an ICR Clinician.

3. RAS Timeframes
   a. An initial RAS shall be completed by day 10 of an admission. The RAS is based on information available at the time it is conducted and shall not be delayed for the gathering of additional information.
   b. The RAS shall be updated no later than day 20 of an admission, to incorporate any relevant information acquired subsequent to its initial completion.
   c. No later than day 20, the Treatment Team reviews the RAS and determines which SRAs, if any are required or if an IFRA is required.
   d. If, at any point during a Patient's admission, new information is obtained that warrants a SRA not previously required, that new information, and the requirement for the new SRA, shall be added to the RAS. This includes new information indicating a previously unknown requirement for an IFRA.

4. Whenever risks are identified as requiring a SRA in any Risk Domain, that Risk Domain shall be addressed in the Patient's Treatment Plan.

F. Specialized Risk Assessments (SRA) and Independent Forensic Risk Assessments (IFRA)

1. The completed RAS is comprised of all available and relevant risk information and the responsible clinician's assessment whether there is a history of significant behavioral risk in the Risk Domains of violence, problematic sexual behavior, fire setting, suicide, and/or substance use for which the Treatment Team should consider completion of one of the following SRAs or request consultation from

the DMH Mentally Ill Problematic Sexual Behavior (MIPSB) program, in addition to any required IFRA:

a. Specialized Violence Risk Assessment or, for Patients committed for forensic evaluation, an evaluation by a forensic clinician that includes a risk assessment and recommendations for the need for care and treatment
b. Specialized Fire Setting Risk Assessment
c. Specialized Suicide Risk Assessment
d. Specialized Substance Use Risk assessment

2. In addition to collating information necessary for determining the need for Specialized Risk Assessments, the RAS is used to determine and document the need for an IFRA in accordance with DMH Policy, i.e. whether the individual has been convicted or adjudicated incompetent to stand trial or not guilty by reason of insanity for certain crimes.

3. The minimum elements for each of the Specialized Risk Assessments are approved by the DMH Office of Inpatient Management (OIM) in consultation with the DMH Deputy Commissioner for Clinical and Professional Services and the DMH Assistant Commissioner for Forensic Services and shall be reflected in Facility-specific protocols.
   a. At the discretion of the FMD, a contracted specialist's consultation report with risk mitigation recommendations may be accepted as a Specialized Risk Assessment in-lieu of the OIM approved guidelines for SRA reports.
   b. If a Patient has a history of behaviors documented in the RAS for which the Treatment Team during the Team Risk Review determines multiple SRAs may be indicated, the Treatment Team should collect the data components for each risk domain but may consider integrating the data into a single unified specialized risk assessment and recommendation(s), provided that the necessary unique static and dynamic variables of each risk domain are documented.

4. Not all risk behavior or history of risk identified through the admission assessments, completion of the RAS, or throughout the inpatient stay necessarily require a SRA. The Team Risk Review processes should:
   a. assure that any new risk information that would change the determination of need for specialized risk assessment is documented in the RAS.
   b. consider the RAS clinical threshold guidelines to determine when a SRA should be considered for completion.
   c. provide a clinical risk rationale each time that completion of a SRA is recommended.
   d. determine which SRA tool(s) will be utilized in completing the risk assessment in the context of the Patient's legal status and likely duration of inpatient treatment.

5. For each Patient whose RAS review establishes the need for any SRAs, the Treatment Team shall prioritize the required SRA(s) based on clinical and

discharge decision-making need, and complete them as soon as possible, but no later than 90 days from the Patient's admission or for Patients on a forensic evaluation status, their conversion to a treatment status. If the Patient is not able to participate in the SRA due to clinical status or chooses to not participate with the SRA, the SRA may be completed based on all available information.

6. In situations in which a newly admitted Patient has previously had a SRA completed in the same risk domain identified in the RAS:
   a. The previous SRA may be used unless there are relevant events, additional assessments, or other significant data that have come to light since the completion of the previous SRA, in which case a new SRA shall be completed.
   b. If there are questions about whether the new information is relevant or significant enough to require a new SRA, the FMD shall be consulted in order to determine what, if any, further SRA is required. Any such consultations with the FMD shall be documented on the RAS by the Treatment Team.
   c. Mandatory IFRA's must be completed in accordance with the IFRA Policy.

7. The progress of specific SRA-recommended risk-mitigation interventions must be reflected in ongoing treatment and discharge planning documentation in each Patient's medical record.

G. Team Risk Reviews

1. The initial Team Risk Review occurs during the Treatment Plan development process so that treatment and recovery goals and interventions related to risk considerations are addressed as early as possible in the admission.
   a. In the development of the Patient's Treatment Plan the team will consider and incorporate relevant risk information collected in the RAS, and any available prior inpatient or outpatient assessments, in determining treatment goals and interventions.
   b. The Patient's Treatment Team will review RAS-based recommendations for SRAs and determine whether one or more SRA(s) should be completed individually or in combination pursuant to IV.F.3.
   c. After completion of a Patient's SRA(s), if any, or any updates to a Patient's RAS, the Treatment Team will incorporate any additional warranted risk goals and interventions at the Treatment Plan review meeting.

2. Subsequent to the initial Team Risk Review, another Team Risk Review is required:

   a. whenever the Treatment Team is deciding about a Patient's access or discharge at the following thresholds (note that a single Team Risk Review may address more than one of these decision points):
      i. Off-grounds Access
      ii. Unsupervised Access

iii. Submission of a 16(e) 30-day notice of Intent to Discharge a Patient committed pursuant to pursuant to M.G.L. c.123, §§16(b) or 16(c)
iv. Discharge

b. whenever the Treatment Team is reconsidering whether to reinstate a Patient's access after the Patient's access level has been reduced due to a significant behavioral occurrence; or
c. when the Patient's Treatment Plan proscribes a specific frequency of Team Risk Reviews.

3. The Team Risk Review is conducted by the Treatment Team under the direction of the Psychiatric Attending or designee.

   a. The Treatment Team reviews all information available including:
      i. the RAS;
      ii. the findings and recommendations of any required or elective SRAs or IFRA;
      iii. a brief summary of treatment progress and observations regarding the extent to which risk mitigation goals/recommendations from Specialized Risk Assessments, and IFRA, if applicable, have been accomplished.
   b. Based on the information reviewed, the Treatment Team:
      i. determines whether recommendations from the required or elective SRAs or IFRA need resolution during the Patient's hospitalization or further integration into discharge planning;
      ii. updates the treatment plan as appropriate; and
      iii. determines whether further review by the Facility Medical Director and others is required before the Treatment Team may proceed with Off-grounds Access, Unsupervised Access, submission of a 16(e) 30-day notice of Intent to Discharge, or discharge [See Section IV.I, below].
   c. The proceedings and findings of the Team Risk Review are documented in the medical record.

H. Consultation Regarding a potential Discharge with Incomplete ICR Policy Implementation

1. It is expected that requirements of this policy will be completed, taking into consideration commitment expiration dates and other circumstances that may lead to early discharge (e.g., pending commitment appeal).

2. If the provisions of this policy are likely not to be fully executed, because the Psychiatric Attending decides that standards to file for commitment are not met, or when considering submitting a 16(e) 30-day notice of Intent to Discharge; or when the Psychiatric Attending, in consultation with the DMH legal office, believes there is a reasonable chance that a commitment petition will be unsuccessful and lead to the discharge of a Patient, the Psychiatric Attending will notify the FMD and COO. The Psychiatric Attending shall be responsible for ensuring that the following actions are undertaken:

a. The Psychiatric Attending will consult the FMD for the purpose of ensuring that risk history and assessment is fully integrated into the risk-mitigation decision-making appropriate for the circumstances.
b. The FMD will coordinate the assessment of, and response to, a potential discharge with incomplete ICR policy implementation, and must notify the AMD of the DMH Area in which the Facility is located, as well as the AMD of the Patient's DMH Area-of-Tie if applicable. If the Patient meets criteria for an IFRA, both AMDs must participate in the consultation.
c. Whenever possible, the consultation with the FMD will include other members of the Treatment Team and the ICR Clinicians who have worked on or completed the SRAs.
d. When the review involves a Patient on the adolescent continuing care units, the AMD will ensure involvement with the applicable DMH Area child psychiatrist and/or the Central Office Child Youth and Family (CYF) Division's Medical Director.

3. The FMD, COO or AMDs may, as appropriate, include other relevant Facility area, or central office staff in consultations required under this section.

4. The FMD will ensure that there is medical record documentation of participants, notifications made, and a summary of the clinical discussion and decisions made relevant to the need for continued hospitalization and proactive contingency planning should a discharge occur.

I. Facility Medical Director (FMD), Area Medical Director (AMD), Central Office Reviews

1. Any necessary FMD, AMD, or Central Office Risk Reviews shall be completed no later than 7 days of their receipt of the necessary risk review paperwork.

2. A FMD Risk Review is required before an order allowing Off-grounds Access, Unsupervised Access, discharge, or before a 16(e) 30-day notice of Intent to Discharge is submitted, when the Team Risk Review identifies any of the following circumstances:
   a. A Patient who meets criteria for an IFRA is being considered for Off-grounds Access with hospital staff supervision; in these cases, an IFRA does not have to be completed before the FMD Review.
   b. A Patient who meets criteria for an IFRA is being considered for Unsupervised Access, submission of a 16(e) 30 day notice of Intent to Discharge, or discharge; in these cases, an IFRA must be completed before the FMD Review.
   c. A Patient is at risk of discharge with Incomplete ICR Policy Implementation (see section H above).
   d. A Patient who does not meet IFRA criteria is being considered for Off-grounds Access, Unsupervised Access, submission of a 16(e) 30-day notice of

Intent to Discharge, or discharge, and one or more of the following criteria are met:

i. The RAS has specified past risk-behaviors above the threshold requiring at least one SRA, and the risk-mitigation recommendations of a SRA have not been satisfied.
ii. The Treatment Team disagrees with the risk mitigation recommendations identified in the pertinent SRAs.
iii. The Facility Medical Director or COO has determined that a review is necessary, or the AMD, Area Director or DMH Central Office requests a review.

3. The Treatment Team shall submit to the FMD a Risk Review Referral Packet for any required Risk Reviews.

4. When a FMD Risk Review pertains to a Patient in an adolescent continuing care inpatient unit, with a complex clinical and risk profile, the FMD should consult with the DMH Area child psychiatrist or the Central Office Child Youth and Family (CYF) Division's Medical Director as part of the FMD risk review process.

5. An AMD Risk Review is required before an order for discharge is written, or before a 16(e) 30-day notice of Intent to Discharge is submitted, when the Team Risk Review or FMD Review identifies either of the following circumstances:
   a. A Patient for whom an IFRA is required is being considered for submission of 16(e) 30-day notice of Intent to Discharge, or a planned discharge, or is at risk of discharge with Incomplete ICR Policy Implementation; in these cases, the AMD of the DMH Area responsible for the Patient's community services conducts the AMD Risk Review.
   b. The FMD, COO, AMD, Area Director or DMH Central Office requests a review.

6. FMD and AMD Risk Reviews conducted pursuant to this section may include, but are not limited to:
   a. Review of the Patient's risk history, as outlined in the RAS, SRA(s) and IFRA(s) (if any).
   b. Review of SRA recommendations.
   c. Review of the Treatment Team Risk Review(s).
   d. Consultation with the Psychiatric Attending, Treatment Team, and community providers, as needed, at the FMD/AMD reviewer's discretion.
   e. Interview of the Patient, as needed, at the FMD/AMD reviewer's discretion.

   A FMD and AMD Risk Review must be documented in the Patient's medical record.

7. Central Office Risk Reviews
    a. In accordance with DMH MI/PSB guidelines, a Central Office Risk Review is required when considering the discharge of a Patient requiring a MI/PSB SRA and IFRA due to their Level III status.
    b. The FMD and AMD, in consultation, may request a Central Office Risk Review.
    c. The FMD must ensure a Central Office Risk Review is documented in the Patient's medical record.

V. STAFF TRAINING, COMPETENCIES, CREDENTIALING AND PRIVILEGING

1. Interdisciplinary staff members associated with Treatment Teams (minimally the Psychiatric Attending, Clinical Social Worker, Psychologist and Nurse) must complete a training related to this policy, with annual or other updates, as determined by the DMH OIM. Facilities implementing this policy pursuant to a contract with DMH shall utilize DMH approved training curricula and shall approve or credential clinicians in a manner consistent with this policy.

2. ICR Clinicians who take responsibility for conducting the RAS must complete the RAS training curriculum and be granted privileges for risk screening, according to Facility medical (professional) staff bylaws.

3. As applicable, ICR Clinicians must be granted privileges by the Facility medical (professional) staff credentialing and privileging process on the basis of competencies validated through ongoing professional practice evaluation (OPPE) processes.

VI. POLICY IMPLEMENTATION

A. The Facility Chief Operating Officer is responsible for:

1. Ensuring that Facility clinical leadership and Treatment Team members are informed of, and adhere to, the requirements of this policy.

2. Tracking the timeframes of commitments and needed risk assessments, and ensuring the timely completion of the RAS and SRAs by Facility staff.

3. Overseeing, along with Facility clinical leadership, the adequacy of the completed RAS and SRAs, including through the process of evaluating the risk assessment competencies and privileging of the ICR Clinicians.

4. Providing resources and establishing processes for the timely and efficient acquisition of the records needed for risk assessment and treatment planning.

5. Providing Peer Support and Human Rights resources, if requested by a Patient, per Section IV.C.2.

B. The Facility Medical Director is responsible for:

1. Ensuring that Psychiatric Attendings are informed of, and adhere to, the requirements of this policy, including the requirements for timeliness and quality of assessments, reviews and risk mitigation interventions.

2. Making the final determination of what, if any, additional SRAs shall be done to supplement previously completed SRAs, per Section IV.F.3.

3. Conducting FMD Reviews, as outlined in Section IV.I.

4. Coordinating the response to potential discharges with Incomplete ICR Policy Implementation, [see Section IV.H.].

5. Involving the Area Medical Director(s), the Area Child Psychiatrist, the Central Office CYF Medical Director, and other consultants, in a timely manner, as required by this policy.

C. The Area Medical Director is responsible for:

1. Providing consultation to the FMD and the COO on the implementation of this policy.

2. Conducting AMD Reviews, as outlined in Section IV.I.

VII. REVIEW

This policy and its implementation shall be reviewed annually.

VIII. REFERENCED DOCUMENTS

A. Risk Review Referral Packet
B. ICR Records Requirements and Guidance
C. Risk Assessment Summary (RAS)
D. Specialized Violence Risk Assessment
E. MI/PSB Referral Form
F. Specialized Fire Setting Risk Assessment
G. Specialized Suicide Risk Assessment
H. Specialized Substance Use Risk Assessment