

FILE REVIEW TIPS

The purpose of a file review is to develop a comprehensive understanding of the consumer by identifying historical information relevant to the current assessment. The amount of information that should be reviewed is best determined by considering the purpose of the file review.

Ask yourself questions such as “do I have a good understanding of the consumer’s history of risk behaviour (e.g. type of harm, when it occurred, and the context) and the associated static and dynamic factors?”.

Some strategies that may assist in conducting a file review are as follows:

1)	A timeline can be a useful approach to make sense of a complex history. A timeline should include: key life events, indicators of symptom exacerbation/crisis (e.g. admission), and episodes of high risk (violence or offending).
2)	The review of the CIMHA record can be expedited by saving the clinical notes as a Clinical Note Display Report. Such a file can be scrolled through far more quickly than opening individual records. A large record may need to be saved as several documents. In addition to reviewing key documents, key word searches can be conducted (e.g. aggression, violence, weapon, or other descriptors of current behaviours of concern (such as stalk, fire, threat)) to ensure key incidents have not been missed.
3)	RiskMan and PRIME incident reports are one method to identify key inpatient incidents.

Unless the clinical record and period of contact with mental health services is brief, the focus will be on reviewing a representative sample of key documents rather than a review of the entire clinical record. Additional tips relating to file review include:

1)	<p>Review key documents from the previous 6-12 months. Should these summary documents identify behaviours or incidents of concern, the reviewer can work backwards to access particular clinical notes which may provide additional incident specific information, including changes that occurred in the period before the behaviour of concern. Key documents may include:</p> <ul style="list-style-type: none"> - Medical reviews - Involuntary patient and voluntary high-risk patient summary - Previous risk screens - Clinical Reports (Forensic Order or ITO). - Assessment reports (including CFOS risk assessments) - Transfers of care - Police contact (EEOs) - Alerts (including old alerts) - The MHA tab, forms on CIMHA for Court Liaison Service reports, and the Forensic Dossier.
2)	The period of first mental health service contact/admission may contain more detailed historical information as well as important information about premorbid functioning. If the consumer has been on a Forensic Order, the forensic dossier may be available from the administration delegate. The dossier will contain details of the index offence and reports considered by the Mental Health Court, including s238 /Chapter 4 reports.
3)	It is useful to check if a person has had a High Secure or Secure Mental Health Rehabilitation Unit admission and why.
4)	CFOS risk assessment reports or case conference notes may be available for review.
5)	Prison Mental Health service contact may be appropriate to review.
6)	Previous psychology reports may contain an outline of mental health, criminal/forensic functioning, and other relevant history.
7)	Identifying factors which enhance stability is an important part of file review.

The overall aim of the file review is to identify previous violence or concerning behaviours and the circumstances associated with this, including mental health and psychosocial factors. It is always useful to note what sources of information were included in your file review.

