Queensland Government

Mental Health Services Violence Risk Assessment and Management

Facility: INPATIENT
Date: Time:

(Affix identification label here)

URN:

Family name:

Given name(s): **Peter**

Address:

Date of birth: XX/XX/XX Sex: ☒ M ☐ F ☐ I

Mental Health Act status

☐ None	☐ Forensic order (mental health)	☐ Treatment support order	☐ Transfer recommendation
☐ Examination authority	☐ Forensic order (disability)	☐ Person AWA (interstate)	☐ Classified (involuntary)
☐ Examination/judicial order	☐ Forensic order (criminal code)	☐ Recommendation for assessment	☐ Classified (voluntary)
☒ Treatment authority			

Conditions of order:

☐ An interpreter was used

Purpose of assessment (note clinical rationale, referral reference, factors requiring action, and the goal of the assessment)

Referred by ward staff to determine risk increasing factors for ongoing violence risk, and to establish a comprehensive management plan. Distinguish violence risk from mental health symptomatology. Inform long-term treatment.

Background summary

Provide relevant context (see Longitudinal Summary and update as needed). Consider:

- Age
- Diagnosis, symptoms and medication
- Psychiatric history
- Substance use
- Forensic history and current legal issues
- Risk history.

Peter is a 40 y/o male who grew up in Sydney. In his early 20s he moved to Brisbane to live with sister (Rebecca). When aged 34, he moved back to Sydney to live with parents about 6 months post-discharge from hospital. Approximately 1 month ago, age 40, he moved back to Brisbane to live with Rebecca following assault of uncle (Tim).

Peter is diagnosed with schizophrenia with likely onset around age 19; he had identified that this as the age which the 'Illuminati' singled him out for special missions. His symptoms include auditory hallucinations of the 'Illuminati', grandiose and persecutory delusions and mental state deterioration is accompanied by a decline in activities of daily living (ADLs), including day to day functioning. Over the years he has typically maintained employment and when well is described as likeable.

He has a history of substance use. He started drinking age 17, commenced cannabis and amphetamines soon after, history of using sedatives (Xanax, Valium) when becoming overwhelmed with auditory hallucinations.

He is currently under a Treatment Authority (TA). This is his second known admission. Brought in by sister Rebecca (who he was living with) after she found two large kitchen knives hidden in Peter's room in context of menacing behaviour towards her boyfriend (Steve), including threats to shoot him in his sleep (muttered by Peter to Steve). Peter had incorporated Steve into persecutory beliefs. Has current and historical delusions that he receives messages from the 'Illuminati' (auditory hallucinations) informing him of people who are 'bad'. Also believes that it is his responsibility to stop 'bad people'. He was not engaged in treatment at the time of this admission.

His first admission was 6 years ago and fell out of care not long after.

Two known incidents of violence (1 month ago, 6 years ago) in the context of psychotic symptoms, as well as reports of pub fights in his 20s in the context of substance use.

Nil known criminal charges.

Peter was not at risk of suicide or vulnerability.

Consumer's previous violence/other problem behaviours and the context in which they occurred (note first known violence including domestic/family violence; problem behaviours e.g. stalking, fire setting and threats; any pattern; increasing frequency or severity of harm; evidence of weapon use; and details regarding previous victims)

Approx. 1 month ago

Peter beat his uncle (Tim) in the front yard of his parent's house in Sydney (where he was living at the time). Tim was punched several times in the head; no weapons were used. Resulted in bruising and headaches, scans were required to confirm no lasting damage. Immediately prior to this incident, Peter had called the police to report Tim for harming his mother. The police arrived and found that this claim was unsubstantiated. When Peter realised the police would not take action against Tim, he reported he beat Tim with the aim of preventing harm to his mother.

For some time prior to this incident, Peter had been experiencing auditory hallucinations of the 'Illuminati' telling him that Tim was assaulting his mother, visual hallucinations of bruises on his mother, and had the delusional belief that it was his responsibility to punish Tim for this to stop him assaulting Peter's mother. Collateral reports from Rebecca suggest that it is unlikely that Tim was assaulting his mother. Police were not called about Peter's assault of Tim, and Tim did not press charges. Peter then left for Brisbane to live with Rebecca immediately following this incident.

In 20XX (age 34) – 6 years ago

Peter was admitted after he hit a police officer, reportedly as a result of hearing voices from the 'Illuminati' telling him that the officer was a paedophile. His was reportedly impulsive (not premeditated). Peter also believed that he had 'secret powers' and an unusually high intellect at this time. Peter had been drinking immediately prior to this incident. Urine drug screen (UDS) was positive for cannabinoids and amphetamine. Admitted to hospital at this time due to psychiatric concerns. Engaged briefly in community treatment but soon failed to attend appointments – moved to Sydney to live with parents without informing treating team approx. 6 months post-discharge. Queensland Police Service (QPS) declined to press charges for assault on police officer, given Peter's mental health problems.

Earlier violence

Reported occasional pub fights in his 20s while intoxicated with people he found annoying to get them to 'shut up' or 'teach them a lesson'. He has reported that no one was significantly hurt, and he was not charged. The fights were started by Peter when 'people are talking rubbish'. He said he usually went for 'one good hit' then stopped. He intended for the punch to teach victims a lesson, and to 'get them to shut up'. After this Peter did not feel the need to continue the fight. Peter confirmed he was not being treated for 'the voices' he was also experiencing around this time.

Static/predisposing factors associated with previous violence

Consider:

- Violence
- Pro-violence attitudes
- Antisocial behaviour
- Relationships
- Employment
- Problematic substance use
- Personality disorder/s
- Other mental disorders (including cognitive impairment, brain injuries, learning disabilities)
- Traumatic experiences
- Treatment adherence and response to treatment

Child and Youth also consider:

- Peer group/influences
- School achievement/engagement.

- History of trauma (Peter was sexually assaulted by a male teacher in Grade 10).
- History of violence.
- Previous diagnosis of schizophrenia.
- Substance use history.
- Prior admission to hospital 6 years ago. Lost to follow-up.
- Factors previously identified on risk screen: anger, impulsivity, treatment non-adherence, violence ideation, symptoms of psychosis, secreting weapons (knives).

Dynamic factors that precipitated previous violence

Consider:

- Insight
- Violent ideation
- Symptoms of major mental disorder (including cognitive impairment, brain injuries, learning disabilities, and dementia)
- Problematic substance use
- Treatment adherence and response to treatment
- Living situation
- Social situation
- Stress/coping
- Anger
- Impulsivity

Child and Youth also consider:

- Peer influence

- Falling out of treatment.
- Auditory hallucinations and persecutory/grandiose delusions of victims assaulting others or being paedophiles, and Peter being on a mission from the 'Illuminati' to stop this.
- Lack of insight into mental illness and violence risk.
- Alcohol use (linked with violence in 20s).
- Where he was living/access to victims.
- Secreting weapons (knives).
- Anger.
- Impulsivity.

Dynamic factors that contribute to current and future risk of violence, including foreseeable changes that could quickly increase risk state

- Ongoing active symptoms of schizophrenia (Similar symptom profile preceded previous violent incidents):
  - Ongoing delusions about Steve being a 'bad guy' and that he will hurt Rebecca and requesting to call police.
  - Currently responding to non-apparent stimuli, voices of 'the 'Illuminati'' telling Peter that Steve is a 'bad guy', that he'll hurt Rebecca, that he'll cheat on Rebecca, and that he's a paedophile.
  - Psychotic rationalisations/justifications leading to a willingness to use violence to protect Rebecca from Steve.
- 'Menacing' behaviour towards Steve prior to admission which was escalating in intensity: Glaring, following around room with eyes, asking Rebecca if Steve hurts her, asking Rebecca if Steve is a paedophile, 'I'll find out what you did, just wait until I have proof' and 'If you've actually done it, you'll pay. I'll shoot you in your sleep'.
- Has been hiding knives in his bedroom in anticipation of altercation with Steve (according to Rebecca).
  - Some evasiveness and incongruence in self-report about location of knives.
- Denied access to guns, but reports willingness to shoot Steve.
- Rebecca reports that Peter has threatened to shoot Steve in his sleep.
- Self-isolating before admission to hospital – spending most of time in room, no close friends.
- Decline in ADLs prior to admission (especially eating, sleeping, washing clothes, showering).
- Limited insight into his diagnosis, nature of mental health problems, current risk, need for treatment and consequences of declining treatment.

Foreseeable changes

- Sister recently informed staff that Peter can no longer reside with her. Parents also can no longer care for Peter.
- May abscond from hospital to pursue Steve - especially once informed he can no longer live with Rebecca.
- Peter may leave the state without informing health services.
- Given previous pattern of moving following violent incidents, some risk that Peter will leave Queensland without informing health services.
- Given Peter's delusional belief that Steve is a paedophile, the risk to Steve is likely to increase if Rebecca falls pregnant.

Specific inpatient dynamic risk factors

Consider:

- Confused/over-excited behaviour
- Irritable/sensitive to provocation
- Physically/verbally threatening/property damage
- Impulsivity
- Unwilling to follow directions/angered when requests are denied.

Current inpatient

- Peter reported he was 'fine' and ready for discharge. He wants to go home to see his sister/doesn't think he needs to be in hospital. He does not agree with views that he has a diagnosis of schizophrenia.
- Some concern regarding ongoing agreement with oral medication although states he will take it on the ward. Team is planning to switch to depot.
- Risk of absconding/absent without approval (AWA) identified by Principal Service Provider (PSP). May abscond from hospital to pursue Steve (especially once informed he can no longer live with Rebecca).
- Ongoing delusions about Steve, gets angry when discussing Steve. Likely risk if Steve enters the ward.

Protective factors and strengths

Consider:

- Treatment adherence and response to treatment
- Coping/social skills
- Stable living situation
- Stable mental/emotional state
- Relationships/supports
- Available resources (readily accessible)
- Insight/awareness of triggers
- Meaningful time use

Child and Youth also consider:

- Peer relationships, supports and activities.

- Previously responded well to anti-psychotic medication and reported Valium or Xanax dampen down voices (treatment helps).
- Appears to be abstaining from cannabis and amphetamines.
- Supportive family (however can no longer reside with sister). Parents in Sydney, regular phone contact. Supportive sister in Brisbane.
- Can manage ADLs and finances independently when well.
- Completed high school achieving average to above average grades. Maintained friendships.
- Went to university, studied engineering (left early) then completed a course in hospitality with financial support of parents.
- Reported having friends through work, school in the past.
- Peter has had only a few periods of unemployment. Generally, works in hospitality e.g. cafes.
- Currently employed as a kitchen hand in a restaurant – reportedly gets along with restaurant staff and has a good work ethic.
- Peter has no criminal history and reportedly never shot a gun.

Violence risk summary

Consider risk status (relative to others in a stated population) and risk state (relative to self at baseline or during previous significant periods) informed by static and dynamic factors:

- Specific population needs (e.g. general population, community settings, inpatient settings)
- Probable nature and imminence of future violence
- Most likely targets of violence (victims)
- Factors that mitigate risk
- Factors that could increase risk
- Potential high risk scenarios

Presenting problem

- Peter's 'menacing' behaviour towards his sister, Rebecca's boyfriend, Steve. Including accusations of Steve being a paedophile, hiding knives to defend Rebecca from Steve, and threats to harm/shoot Steve.
- Background of two significant violent assaults (1 month and 6 years ago), as well as pub fights in his 20s.
- The intensity of these incidents appears to be escalating over time

Predisposing factors

- Trauma - sexual assault by a male schoolteacher in grade 10 – not disclosed/reported.
- History of perpetrating *physical* violence, commencing in his 20s.
- History of symptoms of schizophrenia which influence him to form suspicions about specific people (uncle and Steve), including:
  - grandiose delusions of having special powers and being chosen by the 'Illuminati' to receive information.
  - persecutory delusions of the 'Illuminati' identifying people who are a risk to others.
  - auditory hallucinations of the 'Illuminati' speaking to him, telling him who is 'bad' or 'a paedophile'.
- History of alcohol, cannabis, amphetamine and sedative use.

Precipitating factors

- Absence of treatment.
- Active psychosis (as outlined above).
- Exposure to people that Peter found annoying or thought were 'talking rubbish'.
- While in his 20s, intoxication combined with untreated psychosis seemed to be featured.

Perpetuating factors
- Ongoing hallucinations and delusions (both persecutory and grandiose).
- Associated poor judgement/psychotic reasoning that leads him to see violence as a legitimate way to protect Rebecca/mother.
- Lack of stable treatment for his psychotic symptoms.
- Limited insight.
- Homeless (he cannot return to his sister's).
- Potentially, use of substances (requires further assessment).

Protective factors
- Supportive family (close relationship with sister, regular phone contact with parents).
- Current employment, seem supportive. Only a few periods of unemployment.
- Previously responded well to anti-psychotic medication.
- Appears to be abstaining from cannabis and amphetamines.
- Can manage activities of daily living (ADLs) and finances independently when well.
- Completed high school achieving average to above average grades. Maintained friendships.
- Started university and went on to complete a course in hospitality.
- Nil criminal history.
- He has reportedly never shot a gun.

High risk scenarios
- Relapse of psychotic symptoms of the nature outlined above, together with disengagement from care and an absence of assertive management/treatment.
- Exposure to individuals that Peter finds annoying or who have been incorporated into his delusions, alcohol or other substance use, and/or a belief that authority figures are not doing enough to protect people Peter thinks are potential victims of harm.
- If Rebecca became pregnant to Steve and if Peter was unwell/became unwell given Peter's statements while recently unwell that 'your boyfriend's a pervert, you can't have a baby with him'.

Early warning signs
- Talking about the 'Illuminati' and them having missions for him and/or telling him particular people are 'bad' or 'paedophiles'.
- Making accusations that people are harming others, asking if someone is hurting female family members or a paedophile, staring at people he is fixated on.
- Hiding weapons.
- Sending photos of evidence of perceived (delusional belief) harm.
- Calling the police to inform them of (unsubstantiated) harm by people incorporated into Peter's delusions e.g. Steve/Uncle Tim.

Foreseeable changes
- When informed he cannot return to live with his sister: if he is still experiencing the same symptoms, this stressful situation may feed into false belief/hallucinations about Steve (he may see him as the reason) and he may escalate due to this or to try to protect her.
- Rebecca possibly becoming pregnant (risk to Steve will increase if Peter still believes that Steve is a paedophile).
- Peter may leave disengage and/or leave the state following discharge given past behaviour.

Victim group
Currently, the person at greatest risk appears to be Steve, as Peter has identified Steve as a target for aggression. However, more broadly, anybody incorporated into his persecutory delusional beliefs is at risk. Previously, this has been men and driven by delusional beliefs about protecting women (his mother/Rebecca) and children. Peter has reported that nobody else has been incorporated into his beliefs at present.

Probable nature of future violence
Peter has exhibited a pattern of escalation in his violence. Initially, he was participating in pub fights, he then punched a police officer in the chest, after which he punched his uncle several times in the head and was recently hiding knives in his room and threatening to shoot Steve. This pattern suggests that Peter's next episode of violence may be serious, and more likely to involve a weapon.

Imminence of future violence
In the hospital environment, Peter does not appear to be at imminent risk of future violence as no one there has been incorporated into his delusions. He is also regularly monitored in this environment, including for symptoms, medication adherence, and access to substances. He has limited access to weapons, and he does not have access to Steve in hospital. As Peter continues to experience delusional beliefs and given many of the precipitating and perpetuating factors are still present, he maybe at imminent risk of further violence if he were to leave hospital.

Risk status
Currently, Peter's risk of violence is higher than others accessing care in an inpatient setting as he has ongoing active psychosis incorporating an identified a victim (Steve), made threats towards this victim, and has been hiding weapons in anticipation of an altercation with this victim. He has limited insight into his need for treatment (including medication) and requires ongoing close monitoring and restriction of leave to manage his risk.

Risk state
Peter's current level of risk is higher than when he beat his uncle one month ago because he continues to display similar symptoms (i.e., persecutory delusions and hallucinations about a specified victim), he has now begun hiding weapons and because previous incidents of violence have been in the context of symptoms of psychosis.

Prevention oriented risk management plan

Identify what actions are required for **each** dynamic risk and protective factor, including safety planning with the consumer/carer/family/support networks/potential victims.
Risk management strategies must be incorporated into the consumer Care Plan.

Risk increasing factor	Clinical goal	Preventative strategies, interventions and involvement of other service providers
Disengagement from care/treatment	Long term meaningful care	Maintain an assertive, trauma informed and compassionate based engagement approach with Peter and family. Consider using a motivational interviewing approach and psychoeducation to increase insight into the need for engagement. Ongoing daily serial MSE and risk screens while on the inpatient unit, reconsider frequency on discharge.
Active symptoms of psychosis	Manage symptoms	Ongoing assertive longer term case management. Treatment with anti-psychotic medication. Consider depot long term to aid adherence. Regular medical reviews. Monitor responsiveness/side effects via serial medical/MSE/risk reviews.
	Monitoring who is incorporated into delusions	Ensure treating team (including all nursing staff) are aware of Peter's delusions. Staff to enquire about incorporation of others into delusions and update CIMHA alerts as required.
	Maintain adherence to treatment	Manage under Treatment Authority as needed. Assign long-term community case manager. Psychoeducation when Peter's mental state is appropriate. Motivational enhancement approach to medication adherence supported by clear understanding of his specific concerns relating to medication.
	Increase insight	Provide psychoeducation around illness, violence and relapse prevention/management. Consider Cognitive Behavioural Therapy (CBT) for psychosis.
	Reduce vulnerability	Complete a Police Advice and Intervention Plan (PAIP) to share relevant clinical history ahead of further possible police complaints to flag that this indicates mental state deterioration and that he needs to be linked with (Mental Health and Other Drugs Services (MHAODS).
Homelessness	Find residence for Peter	Work with Peter, relevant Non-Government Organisations (NGOs) and Department of Housing (DOH) to find a place to live prior to discharge. Referral to long term Case Management (adult mental health or suitable NGO) to support independent living.
	Inform Peter of inability to live with Rebecca in a manner which protects social relationships	Once Peter's insight improves and in a safe setting to manage escalations have an experienced staff member Peter trusts inform him of Rebecca's decision. Engage in psychoeducation around the reasons. Continue ongoing close monitoring over the coming days/weeks. Ensure Peter understands that the service has found/is finding alternative living arrangements prior to discharge.
Risk to Steve	Reduce weapon seeking and access to weapons	Treat psychosis, restrict access to knives and other weapons, regularly check Peter's areas for hidden weapons. Complete a weapons licensing notification to Queensland Police Service (QPS) (https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health), confirm receipt, document in CIMHA and add alert.
	Treating team to take steps to protect Steve wherever possible	Discuss with the domestic and family violence (DFV) Co-ordinator (Contacts and referrals | Queensland Health Intranet) to consider the need for referral as well as advice around victim safety planning. Undertake victim safety-planning with Rebecca and Steve based on the DFV co-ordinators specialist advice around this, e.g. ensuring Steve knows to retreat to a safe place if Peter approaches and call triple zero. Update Steve with advice as the risks resolve. Offer linkage with specialist victim support services. Have a high risk absent without approval (AWA) plan in place re: reporting to QPS via triple zero who can warn Steve or seek legal advice to determine if the treating team need to do this. Ensure all members of Peter's treating team are aware of the risk to Steve, and what behaviours are likely to aggravate these (e.g. accidental collusion with delusional beliefs, Steve visiting the ward). Close monitoring of symptoms related to Steve. All CIMHA alerts have been added and will be updated as required.
Substance use	Minimise harmful use of alcohol, cannabis and methamphetamines	Overarching harm reduction and motivational enhancement approach. Thorough assessment of substance use, including identification of function of use, possible cues and consideration of alternative behavioural strategies. Develop plan for continuing assessment including by urine drug screen (UDS) which is random but targeting likely times of use in a way that he agrees may support harm minimisation
Poor frustration tolerance	Enhance non-violence-based problem solving	Problem solving skills for managing potential threats to the safety of others, CBT for psychosis and ?cognitions around people who 'talk rubbish' and impact on perceived risk, establish consequences for engaging in violent behaviour.
Incomplete information	Gather further collateral	Gather collateral from NSW Health (if he was seen by them) and the Mental Health Intervention Coordinator. Discuss at multidisciplinary team (MDT) meeting and update risk screen, alerts and other forms as required.

Protective factors	Clinical goal	Preventative strategies, interventions and involvement of other service providers
Family Support	Maintain and enhance family members' ability to support Peter.	Hold family meeting with treating team, Rebecca, and Peter's parents (with his consent and via phone). Provide education regarding Peter's symptoms, early warning signs and risks; as well as information about treatment (including rationale), and ongoing management. Brainstorm a plan for likely upcoming challenges, and approaches for managing these.
Current employment	Maintain employment.	Discuss potential impact of time away from job with Peter and family. If desired, provide supportive letter to employer explaining absence. If desired, hold meeting with employer to support ongoing employment.

This assessment is informed by (note engagement with consumer, and sources of collateral)

- CIMHA records – alerts, transfer of care on XX/XX/XX and general assessment on XX/XX/XX.
- Interview with Peter on XX/XX/XX
- Discussion with Mary Nightingale (Peter's PSP)
- Phone interview with Rebecca (Peter's sister).

Information provided to consumer/carer/family/support persons (detail the information provided to the consumer/carer/family/support networks regarding this risk assessment and management plan. Where applicable include obligations under the *Mental Health Act 2016*. Note the consumer/carer/family/support networks understanding of the assessment, risk management plan and clinical goals)

This report will be discussed by the PSP with Peter's treating team at care review tomorrow, XX/XX/XX and the risk management plan will be included in his Care Plan.

Information to be shared with Steve, Rebecca, and Peter's parents regarding Peter's symptoms, risks to family's safety, treatment and rationale, safety plan, and resources to maintain own mental health.

Information about treatment to be shared with Peter, and his input to be incorporated into risk management plan.