

 <p>Queensland Government</p> <p style="text-align: center;">Mental Health Services Violence Risk Assessment and Management</p> <p>Facility: Inpatient Date: _____ Time: _____</p>	<p style="text-align: right;">(Affix identification label here)</p> <p>URN: _____</p> <p>Family name: Care scenario</p> <p>Given name(s): Peter</p> <p>Address: _____</p> <p>Date of birth: 05/03/1980 Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p>																
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Purpose of assessment (note clinical rationale, referral reference, factors requiring action, and the goal of the assessment)																	
<p>Referred by ward staff to determine current and ongoing level of violence risk, and to establish a comprehensive management plan.</p> <p>Distinguish violence risk from mental health symptomatology. Inform long-term treatment.</p>																	
Background summary																	
<p>Provide relevant context (see Longitudinal Summary and update as needed). Consider:</p> <ul style="list-style-type: none"> Age Diagnosis, symptoms and medication Psychiatric history Substance use Forensic history and current legal issues Risk history 																	
<p>Brought in by sister Rebecca for admission 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. Peter had incorporated Steve into paranoid 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'. Historical diagnosis of schizophrenia.</p> <p>Two previous incidents (1 month ago, 6 years ago) of violence in the context of psychotic symptoms.</p> <p>History of alcohol and polysubstance use. Nil identified criminal charges.</p> <p>Grew up in Sydney. In 2004 (age 24), moved to Brisbane to live with sister. In 2012 (age 32) moved back to Sydney to live with parents approx. 6 months post-discharge from hospital. In 2018 (approx. 1 month ago, age 38) moved to Brisbane to live with sister following assault of uncle (Tim).</p>																	
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)																	
<p>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). This involved punching Tim 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 beat Tim with the aim of preventing harm to his mother.</p> <p>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 in order 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.</p> <p>2014 – incident of violence towards a police officer. Peter reported hearing voices from the Illuminati telling him that the officer was a paedophile, so he punched the officer in the chest. This was reportedly impulsive insofar as it was not premeditated. Peter also believed that he had secret powers and an unusually high intellect at this time. Peter had been drinking at a bar immediately prior to this incident. UDS was positive for cannabinoids and amphetamine. Admitted to hospital at this time due to psychiatric concerns. Engaged briefly in treatment with the CCU but soon failed to attend appointments – moved to Sydney to live with parents without informing treating team approx. 6 months post-discharge. QPS declined to press charges for assault on police officer, given Peter's mental health problems.</p> <p>Pre-2014 – Reported occasional bar fights prior to 2014 in the context of amphetamine use, alcohol binge drinking, and occasional cannabis use. No record of prior contact with mental health services in Queensland.</p> <p>Second year university (year unknown) – Peter's symptomatology appeared to worsen – increase in alcohol use, disengagement from university, lost internship, decline in ADLs, observed talking to himself on several occasions.</p> <p>1999 (Peter aged 19) – Peter first reported to be responding to non-apparent stimuli. Peter identified this as the age which the Illuminati singled him out for special missions.</p>																	

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Static/predisposing factors associated with previous violence			
<p>Consider:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> Violence Pro-violence attitudes Antisocial behaviour Relationships Employment Problematic substance use Personality disorder/s </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> Other mental disorders (including cognitive impairment, brain injuries, learning disabilities) Traumatic experiences Treatment adherence and response to treatment <p>Child and youth also consider:</p> <ul style="list-style-type: none"> Peer group/influences School achievement/engagement </td> </tr> </table>		<ul style="list-style-type: none"> Violence Pro-violence attitudes Antisocial behaviour Relationships Employment Problematic substance use Personality disorder/s 	<ul style="list-style-type: none"> Other mental disorders (including cognitive impairment, brain injuries, learning disabilities) Traumatic experiences Treatment adherence and response to treatment <p>Child and youth also consider:</p> <ul style="list-style-type: none"> Peer group/influences School achievement/engagement
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<ul style="list-style-type: none"> Prior admission to hospital – approx. 2014 (6 years ago). Lost to follow-up. Substance use disorder – started drinking age 17; cannabis and speed soon after; smoking cigarettes Grade 10; history of using sedatives (Xanax, Valium) pills when becoming overwhelmed with auditory hallucinations. Previous diagnosis of schizophrenia (present while abstinent from drugs and alcohol). Factors previously identified on risk screen: anger, impulsivity, treatment non-adherence, violence ideation, symptoms of psychosis, access to weapons. 			
Dynamic factors that precipitated previous violence			
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<ul style="list-style-type: none"> Non-adherence with medication treatment. Alcohol and substance use. Auditory hallucinations and paranoid/grandiose delusions of victims assaulting others or being paedophiles, and Peter being on a mission from the Illuminati to stop this. <ul style="list-style-type: none"> – Lack of insight into mental illness Feeling that authority figures (police) were not taking his concerns about 'bad people' seriously. Some decline in ADLs in period preceding previous incidents of violence and deterioration of mental state. 			
Dynamic factors that contribute to current and future risk of violence, including foreseeable changes that could quickly increase risk state			
<ul style="list-style-type: none"> Current symptoms of Schizophrenia – paranoid beliefs. Ongoing delusions about Steve being a 'bad guy', and that he will hurt Rebecca – requesting to call police. Similar symptom profile which preceded previous violent incidents. Currently responding to non-apparent stimuli (voices of Illuminati). Similar symptom profile which preceded previous violent incidents: <ul style="list-style-type: none"> – voices currently 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 – talking to self, pacing, muttering. Delusional beliefs and auditory hallucinations provide a sense of purpose for Peter – ego-syntonic 'Menacing' behaviour towards Steve prior to admission – escalating in intensity: <ul style="list-style-type: none"> – 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 (carving knife) in his bedroom in anticipation of altercation with Steve (according to Rebecca). <ul style="list-style-type: none"> – Some evasiveness and incongruence in self-report about location of knives. Proviolence attitudes – willing to use violence to protect Rebecca from Steve: <ul style="list-style-type: none"> – denies access to guns, but reports willingness to shoot Steve – Rebecca reports that Peter has threatened to shoot Steve in his sleep. Belief that police are easily convinced of the innocence of 'bad people' – increased risk that Peter will resort to vigilantism 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) Declining oral medication Limited insight into nature of mental health problems, current risk, and consequences of declining treatment Difficulty sleeping <p><u>Foreseeable changes</u></p> <ul style="list-style-type: none"> Sister recently informed staff that Peter can no longer reside with her. Parents also can no longer care for Peter. Given previous pattern of moving following violent incidents, some risk that Peter will leave Queensland without informing health services. Given the Peter's delusional belief that Steve is a paedophile, the risk to Steve is likely to increase if Rebecca falls pregnant. 			

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Specific inpatient dynamic risk factors	
<p>Consider:</p> <ul style="list-style-type: none"> • Confused/over-excited behaviour • Irritable/sensitive to provocation • Physically/verbally threatening/property damage • Impulsivity • Unwilling to follow directions/angered when requests are denied 	
<ul style="list-style-type: none"> • Current inpatient • Some concern regarding ongoing agreement to oral medication – ward staff planning to switch to depot. • Risk of AWA identified by PSP. May abscond from hospital to pursue Steve (especially after he is informed he can no longer live with Rebecca), may leave the state without informing health services • Ongoing delusions about Steve, gets angry when discussing Steve. Likely risk if Steve enters the ward • Currently nil known incorporation of staff or fellow consumers into delusions, however this is changeable. 	
Protective factors and strengths	
<p>Consider:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Peer relationships, supports and activities 	
<ul style="list-style-type: none"> • Appears to be abstaining from cannabis and amphetamines. • Supportive family (however can no longer reside with sister). Parents in Sydney, previously regular phone contact. Sister in Brisbane. • Can manage ADLs and finances independently when well. • Currently employed as a kitchenhand in a restaurant – reportedly gets along with restaurant staff and has a good work ethic. However, was taking amphetamines in 2014 to help stay awake during night shift. • Auditory hallucinations about Steve have decreased since admission - ?physical separation from Steve may have reduced hallucinations; re-commencement of medication (began 5 days ago) may also be having a positive effect. 	
Violence risk summary	
<p>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:</p> <ul style="list-style-type: none"> • 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 	
<p><u>Presenting Factors</u></p> <ul style="list-style-type: none"> • Menacing behaviour to Steve: <ul style="list-style-type: none"> – accusations of Steve being a paedophile; threats to harm Steve (including shooting); hiding knives. <p><u>Predisposing Factors</u></p> <ul style="list-style-type: none"> • Past diagnosis of mental illness (schizophrenia; auditory hallucinations, paranoid and grandiose delusions). • History of violent behaviour. • Pro-violence attitude. • Substance use history (cannabis, methamphetamines, benzodiazepines). • Limited social support. <p><u>Precipitating Factors</u></p> <ul style="list-style-type: none"> • Past episodes: <ul style="list-style-type: none"> – non-adherence to treatment for schizophrenia – substance use – command hallucinations – contact with people who ‘talk rubbish’. • Present episode: <ul style="list-style-type: none"> – presence of psychotic symptoms (delusions; preoccupation with providing protection) – belief nobody is protecting potential victims. <p><u>Perpetuating Factors</u></p> <ul style="list-style-type: none"> • Ongoing symptoms of psychosis. • Ego syntonic nature of symptoms – leads to resistance to treatment. • Pro-violence attitude. • Poor ADLs (incl self-isolation) – impacts mental health. • Lack of faith in authority figures – reinforces vigilantism. • Limited insight. • Poor engagement with services – results in lack of treatment. • Substance use. <p><u>Protective Factors</u></p>	

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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
Homelessness	Find residence for Peter	Refer Peter to social worker 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	Devote time for a staff member Peter trusts to inform him of Rebecca's decision to no longer allow Peter to reside with her. Ensure the reasons for this are explained; challenge attributions to Steve if appropriate. Ensure Peter understands that the service has found / is finding alternative living arrangements for Peter prior to discharge.
Risk to Steve	Treat delusions	Medication review; administer medication via depot as Peter currently declining oral medication
	Treating team to take steps to protect Steve wherever possible	Steve to be advised that visiting Peter will likely pose a risk to Steve, and result in a deterioration of Peter's condition. Alert to be placed on CIMHA advising of same. 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). When Peter is advised that he is unable to continue residing with Rebecca, staff to monitor him for changes in delusional content attributing this to Steve. Risk mitigation strategies to be generated as appropriate.
	Inform Steve of risk to him, and risk mitigation strategies	Conduct meeting with Steve and Rebecca to inform them of: <ul style="list-style-type: none"> • Peter's delusional content pertaining to Steve • the risks to Steve's safety Peter's delusional content poses • strategies that Steve can engage in to ensure his safety • a crisis plan for if Peter becomes aggressive or threatening towards Steve • information about services Steve can access to help maintain his own mental health in this situation.
Active symptoms of psychosis	Treat psychosis	Medication review; administer medication via depot due to concern regarding ongoing oral medication adherence (based on history of treatment non-adherence). Plan engagement with Case Worker when mental state is appropriate.
	Monitor Peter to ensure others have not been 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. Restrict leave. Regular obs (2hr).
	Maintain adherence to treatment	Retain TA. Assign long-term Case Manager. Retain contact details for family in case Peter becomes AWA. Complete PAIP. Insight oriented therapy when Peter's mental state is appropriate. Motivational interviewing.
	Address ego-syntonic nature of delusions	Long-term cognitive therapy (when mental state is appropriate) aiming to increase insight into nature of delusions. Motivational interviewing.
Incomplete information	Gather further collateral from NSW Department of Health regarding Peter's involvement with Mental Health, Peter's parents, and the Mental Health Intervention Coordinator	Recommend gathering further collateral from these parties. If information is identified which alters Peter's current risk profile or impacts the risk management plan, PSP to recommend an update to the present V-RAM through MDT meeting.
Substance use	Maintain abstinence from cannabis and amphetamines	Assess patterns of substance use and develop a motivational enhancement or CBT approach to treatment.
	Reduce use of alcohol and sedatives	As above.
Deterioration in ADLs	Maintain ADLs and self-care long-term	Assign Case Manager. Consider referral to Community Care Unit. Consider referral to appropriate NGO.
Exposure to people Peter believes 'talk rubbish'	Reduce exposure to these people	Motivational interviewing aiming to reduce time spent at pubs, CBT to identify delusions early, training to manage social conflict.
Proviolence attitudes and proclivity for vigilantism	Enhance non-violence based problem solving	Problem solving skills for managing potential threats to the safety of others, CBT regarding paranoia and impact on perceived risk, establish consequences for engaging in violent behaviour.

