

 <p><b>Queensland Government</b></p> <p style="text-align: center;"><b>Mental Health Services Violence Risk Assessment and Management</b></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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<b>Purpose of assessment</b> (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. Distinguish violence risk from mental health symptomatology. Inform long-term treatment.</p>																	
<b>Background summary</b>																	
<p>Provide relevant context (see Longitudinal Summary and update as needed). Consider:</p> <ul style="list-style-type: none"> <li>Age</li> <li>Diagnosis, symptoms and medication</li> <li>Psychiatric history</li> <li>Substance use</li> <li>Forensic history and current legal issues</li> <li>Risk history</li> </ul>																	
<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 in his sleep (muttered by Peter to Steve). 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 2006 (age 26), moved to Brisbane to live with sister. In 2014 (age 34) moved back to Sydney to live with parents approx. 6 months post-discharge from hospital. In 2020 (approx. 1 month ago, age 40) moved to Brisbane to live with sister following assault of uncle (Tim).</p>																	
<b>Consumer's previous violence/other problem behaviours and the context in which they occurred</b> (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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<p><b>Static/predisposing factors associated with previous violence</b></p>	
<p>Consider:</p> <ul style="list-style-type: none"> <li>• Violence</li> <li>• Pro-violence attitudes</li> <li>• Antisocial behaviour</li> <li>• Relationships</li> <li>• Employment</li> <li>• Problematic substance use</li> <li>• Personality disorder/s</li> </ul> <ul style="list-style-type: none"> <li>• Other mental disorders (including cognitive impairment, brain injuries, learning disabilities)</li> <li>• Traumatic experiences</li> <li>• Treatment adherence and response to treatment</li> </ul> <p>Child and Youth also consider:</p> <ul style="list-style-type: none"> <li>• Peer group/influences</li> <li>• School achievement/engagement</li> </ul>	
<ul style="list-style-type: none"> <li>• Prior admission to hospital – approx. 2014 (6 years ago). Lost to follow-up.</li> <li>• 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.</li> <li>• Previous diagnosis of schizophrenia (present while abstinent from drugs and alcohol).</li> <li>• Factors previously identified on risk screen: anger, impulsivity, treatment non-adherence, violence ideation, symptoms of psychosis, access to weapons.</li> </ul>	
<p><b>Dynamic factors that precipitated previous violence</b></p>	
<p>Consider:</p> <ul style="list-style-type: none"> <li>• Insight</li> <li>• Violent ideation</li> <li>• Symptoms of major mental disorder (including cognitive impairment, brain injuries, learning disabilities, and dementia)</li> <li>• Problematic substance use</li> <li>• Treatment adherence and response to treatment</li> </ul> <ul style="list-style-type: none"> <li>• Living situation</li> <li>• Social situation</li> <li>• Stress/coping</li> <li>• Anger</li> <li>• Impulsivity</li> </ul> <p>Child and Youth also consider:</p> <ul style="list-style-type: none"> <li>• Peer influence</li> </ul>	
<ul style="list-style-type: none"> <li>• Non-adherence with medication treatment – Peter indicates some uncertainty/disagreement regarding his diagnosis of schizophrenia.</li> <li>• Alcohol and substance use: <ul style="list-style-type: none"> <li>– he reports using Valium and Xanax (non-prescribed) to help him sleep (when his auditory hallucinations are becoming overwhelming)</li> <li>– Peter's pattern of alcohol use in the past suggests that he used to drinking with peer groups and is unable to self-identify when he's had too much. Currently he uses alcohol in combination with Valium and Xanax as a form of self-medication to help him sleep.</li> </ul> </li> <li>• 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"> <li>o lack of insight into mental illness.</li> </ul> </li> <li>• Feeling that authority figures (police) were not taking his concerns about 'bad people' seriously.</li> <li>• Some decline in ADLs in period preceding previous incidents of violence and deterioration of mental state.</li> </ul>	
<p><b>Dynamic factors that contribute to current and future risk of violence, including foreseeable changes that could quickly increase risk state</b></p>	
<ul style="list-style-type: none"> <li>• Current symptoms of Schizophrenia – paranoid beliefs.</li> <li>• Ongoing delusions about Steve being a 'bad guy', and that he will hurt Rebecca – requesting to call police. Similar symptom profile preceded previous violent incidents.</li> <li>• Currently responding to non-apparent stimuli (voices of Illuminati). Similar symptom profile which preceded previous violent incidents: <ul style="list-style-type: none"> <li>– 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</li> <li>– talking to self, pacing, muttering.</li> </ul> </li> <li>• Delusional beliefs and auditory hallucinations provide a sense of purpose for Peter – ego-syntonic.</li> <li>• 'Menacing' behaviour towards Steve prior to admission – escalating in intensity. <ul style="list-style-type: none"> <li>– 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'.</li> </ul> </li> <li>• Has been hiding knives (carving knife) in his bedroom in anticipation of altercation with Steve (according to Rebecca). <ul style="list-style-type: none"> <li>– Some evasiveness and incongruence in self-report about location of knives.</li> </ul> </li> <li>• Proviolence attitudes – willing to use violence to protect Rebecca from Steve. <ul style="list-style-type: none"> <li>– Denies access to guns, but reports willingness to shoot Steve.</li> <li>– Rebecca reports that Peter has threatened to shoot Steve in his sleep.</li> </ul> </li> <li>• Belief that police are easily convinced of the innocence of 'bad people' – increased risk that Peter will resort to vigilantism.</li> <li>• Self-isolating before admission to hospital – spending most of time in room, no close friends.</li> <li>• Decline in ADLs prior to admission (especially eating, sleeping, washing clothes, showering).</li> <li>• Declining oral medication.</li> <li>• Limited insight into nature of mental health problems, current risk, and consequences of declining treatment.</li> <li>• Difficulty sleeping.</li> </ul>	

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<p><u>Foreseeable changes</u></p> <ul style="list-style-type: none"> <li>Sister recently informed staff that Peter can no longer reside with her. Parents also can no longer care for Peter.</li> <li>Given previous pattern of moving following violent incidents, some risk that Peter will leave Queensland without informing health services.</li> <li>Given Peter's delusional belief that Steve is a paedophile, the risk to Steve is likely to increase if Rebecca falls pregnant.</li> </ul>			
<p><b>Specific inpatient dynamic risk factors</b></p>			
<p>Consider:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>Confused/over-excited behaviour</li> <li>Irritable/sensitive to provocation</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>Physically/verbally threatening/property damage</li> <li>Impulsivity</li> <li>Unwilling to follow directions/angered when requests are denied</li> </ul> </td> </tr> </table>		<ul style="list-style-type: none"> <li>Confused/over-excited behaviour</li> <li>Irritable/sensitive to provocation</li> </ul>	<ul style="list-style-type: none"> <li>Physically/verbally threatening/property damage</li> <li>Impulsivity</li> <li>Unwilling to follow directions/angered when requests are denied</li> </ul>
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<ul style="list-style-type: none"> <li>Current inpatient.</li> <li>Some concern regarding ongoing agreement to oral medication – ward staff planning to switch to depot.</li> <li>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</li> <li>Ongoing delusions about Steve, gets angry when discussing Steve. Likely risk if Steve enters the ward.</li> <li>Currently nil known incorporation of staff or fellow consumers into delusions, however this is changeable.</li> </ul>			
<p><b>Protective factors and strengths</b></p>			
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<ul style="list-style-type: none"> <li>Appears to be abstaining from cannabis and amphetamines.</li> <li>Supportive family (however can no longer reside with sister). Parents in Sydney, previously regular phone contact. Sister in Brisbane.</li> <li>Can manage ADLs and finances independently when well.</li> <li>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.</li> <li>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.</li> </ul>			
<p><b>Violence risk summary</b></p>			
<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> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>Specific population needs (e.g. general population, community settings, inpatient settings)</li> <li>Probable nature and imminence of future violence</li> <li>Most likely targets of violence (victims)</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>Factors that mitigate risk</li> <li>Factors that could increase risk</li> <li>Potential high risk scenarios</li> </ul> </td> </tr> </table>		<ul style="list-style-type: none"> <li>Specific population needs (e.g. general population, community settings, inpatient settings)</li> <li>Probable nature and imminence of future violence</li> <li>Most likely targets of violence (victims)</li> </ul>	<ul style="list-style-type: none"> <li>Factors that mitigate risk</li> <li>Factors that could increase risk</li> <li>Potential high risk scenarios</li> </ul>
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<p><b>Presenting Factors</b></p> <p>The presenting problem being examined within this V-RAM is Peter's menacing behaviour towards Steve, specifically his accusations of Steve being a paedophile, hiding knives to defend Rebecca from Steve, and threats to harm Steve. This menacing behaviour occurs on a background of two significant violent assaults (1 month and, and 6 years ago), as well as several bar fights. The intensity of these incidents appears to be escalating over time.</p>			
<p><b>Predisposing Factors</b></p> <p>Peter is predisposed to violence by his historical diagnosis of schizophrenia. Historically, this has involved grandiose delusions (of having special powers and being chosen by the Illuminati to receive information), paranoid delusions (of the Illuminati identifying people who are risks to other, and of other people trying to steal his powers), auditory hallucinations (of the Illuminati speaking to him), and visual hallucinations (of bruises on his mother, whom he believed was being assaulted). Peter also has a history of excessive alcohol use and other substance use, including nicotine, cannabis, amphetamines, and sedatives. Several of Peter's previous violent incidents have been in the context of alcohol and/or drug intoxication. All identified previous incidents of violence have been in the context of symptoms of psychosis. When Peter experiences active symptoms of psychosis, this is typically accompanied by a deterioration in his ADLs. This appears to make him more vulnerable to further deterioration in his mental health, which increases his risk for violence.</p>			
<p><b>Precipitating Factors</b></p> <p>Factors which regularly triggered previous episodes of violence for Peter include: non-adherence to treatment for schizophrenia, alcohol and/or other substance use, auditory hallucinations (especially those relating to people being paedophiles), and exposure to people that Peter found annoying or thought were 'talking rubbish'. Peter's most recent violent attack was precipitated by a sense that the police were not taking adequate heed of his concern that his uncle was harming his mother, and so he resorted to vigilantism. His most recent menacing behaviour towards Steve appears to be precipitated by a general suspicion that Steve is harming Rebecca or children, based on auditory hallucinations informing him of the same.</p>			

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<p><b>Perpetuating Factors</b> Factors which prevent Peter's violence risk from resolving independently include: his ongoing hallucinations and delusions (both paranoid and grandiose), the ego-syntonic nature of these psychotic symptoms, pro-violence attitudes (Peter sees violence as a legitimate way to protect Rebecca), poor self-care/ADLs, lack of stable treatment for schizophrenia, belief that authority figures will not take necessary action to protect potential victims (thus increasing risk of vigilantism), self-isolation prior to admission (thus prolonging identification of problems), and limited insight into his mental health problems, current risk, and consequences of declining treatment. Additionally, Peter has previously exhibited risky behaviours when experiencing psychotic symptoms, including: hiding large knives in his bedroom in preparation for a possible altercation with Steve; and he has reported a willingness to shoot Steve (however he denies current access to a firearm).</p> <p><b>Protective Factors</b> Factors which may slow Peter's deterioration and/or assist in his risk management include: current abstinence from cannabis and amphetamines, supportive family (despite current inability to reside with parents or sister), current employment, decline in symptoms following admission (possibly attributable to commencement of treatment and/or separation from Steve). However, the impact of these protective factors is currently limited due to Peter's state of acute psychosis.</p> <p>It is noteworthy that some internal inconsistencies were identified in Peter's account of aspects of his current presentation, as well as incongruence between self-report and collateral reports. Peter appears to be minimising the severity of his violence risk.</p> <p><b>High Risk Scenarios, Early Warning Signs, and Foreseeable Changes</b> High risk scenarios for future violence for Peter include: the onset of psychotic symptoms, non-adherence to treatment for schizophrenia, exposure to individuals that Peter finds annoying or who have been incorporated into his delusions, alcohol or other substance use, and a belief that authority figures are not doing enough to protect people Peter thinks are potential victims of harm.</p> <p>Early warning signs include deterioration in ADLs, bizarre behaviour (e.g., talking to himself, muttering, glaring), making accusations that people are harming others, hiding weapons, and self-isolation. Foreseeable changes include: Peter discovering he is unable to live with Rebecca and impending homelessness (Peter may attribute this to Steve), Rebecca possibly becoming pregnant (risk to Steve will increase if Peter still believes that Steve is a paedophile). Based on his previous pattern of behaviour, there is also some risk that Peter may leave the state following discharge.</p> <p><b>Victim Group</b> 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 delusional beliefs is at risk. Previously, this has typically been men. Peter has reported that nobody in the hospital environment has been incorporated into his beliefs, however this should be continuously monitored.</p> <p><b>Severity of Violence</b> Peter has exhibited a pattern of escalation in his violence. Initially, he was participating in bar fights, he then punched a police officer in the chest, after which he punched his uncle several times in the head, and is now hiding knives in his room and threatening to shoot Steve. This pattern suggests that Peter's next episode of violence may be severe, and more likely to involve a weapon.</p> <p><b>Imminence of Violence</b> Within the hospital environment, Peter does not appear to be at imminent risk of becoming violent, as no members of staff or fellow consumers have been incorporated into his delusions. He is also regularly monitored in this environment, including for symptoms, medication adherence, and access to substances. He also has limited access to weapons. Additionally, he does not have access to Steve in hospital. However, Peter continues to experience delusional beliefs, and many of his precipitating and perpetuating factors are still present. As such, he would be at imminent risk of violence if he were to leave hospital.</p> <p><b>Risk Status and Risk State</b> Currently, Peter's risk of violence is higher than the general population because he has a historical diagnosis of schizophrenia, is currently experiencing active symptoms, and has a history of violent incidents. His risk is currently higher than that of a typical consumer in a community mental health setting because he has identified a victim (Steve), he has made threats towards this victim, he has been hiding weapons in anticipation of an altercation with this victim, he continues to use substances, and he has limited insight into his for treatment (including medication). His risk is higher than that of most mental health inpatients, because he is currently experiencing untreated symptoms of psychosis, lacks insight into his illness, and requires ongoing monitoring and restriction of leave to manage his risk. 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., paranoid delusions and hallucinations about a specified victim), and has now begun hiding weapons.</p>	

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<b>Prevention oriented risk management plan</b> Identify what actions are required for <b>each</b> 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. This staff member must be appropriately experienced and understand the risks involved. This must occur in a setting in which there is immediate support available if Peter's behaviour escalates. 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"> <li>• Peter's delusional content pertaining to Steve</li> <li>• the risks to Steve's safety Peter's delusional content poses</li> <li>• strategies that Steve can engage in to ensure his safety</li> <li>• a crisis plan for if Peter becomes aggressive or threatening towards Steve</li> <li>• information about services Steve can access to help maintain his own mental health in this situation.</li> </ul>	
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. Supportive therapy when Peter's mental state is appropriate. Motivational enhancement approach to medication adherence supported by clear understanding of his specific concerns relating to medication.	
	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	Minimise harmful use of cannabis and stimulants, including methamphetamines.	Overarching harm minimisation and motivational enhancement approach. Thorough assessment of substance use, including identification of possible cues and consideration of alternative behavioural strategies. Develop plan for continuing assessment including by UDS which is random but targeting likely times of use in a way that he agrees may support harm minimisation	
	Reduce use of alcohol and sedatives.	As above	

 <p><b>Queensland Government</b></p> <p><b>Mental Health Services</b></p> <p><b>Violence Risk Assessment and Management</b></p> <p>Facility: Inpatient Date: _____ Time: _____</p>		(Affix identification label here)			
		URN:			
		Family name: Care scenario			
		Given name(s): Peter			
		Address:			
		Date of birth: 05/03/1980		Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I	
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 techniques 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.			
Hiding weapons	Reduce weapon seeking and access to weapons.	Treat psychosis, restrict access to knives and other weapons, regularly check Peter's areas for hidden weapons.			
Poor insight	Increase insight.	Referral to Case Manager or appropriate NGO for CBT.			
<b>Protective factors</b>	<b>Clinical goal</b>	<b>Preventative strategies, interventions and involvement of other service providers</b>			
Family Support	Maintain and enhance family members' ability to support Peter.	Hold family meeting with treating team, Rebecca, Steve, and Peter's parents (via phone). Provide education regarding Peter's symptoms, 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.			
<b>This assessment is informed by</b> (note engagement with consumer, and sources of collateral)					
CIMHA records – transfer of care 2014, and general assessment on 17/4/20.					
Interview with Peter on 30/4/20					
Discussion with Mary Nightingale (Peter's PSP)					
Rebecca (Peter's sister).					
<b>Information provided to consumer/carer/family/support persons</b> (detail the information provided to the consumer/carer/family/support networks regarding this risk assessment and management plan. Where applicable include obligations under the <i>Mental Health Act 2016</i> . Note the consumer/carer/family/support networks understanding of the assessment, risk management plan and clinical goals)					
This report will be discussed with Peter's treating team at multidisciplinary team review tomorrow 02/05/20.					
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.					
Clinician's name (please print):	Designation:	Signature:	Team:	Date:	Time: