Queensland Government

Mental Health Services Violence Risk Assessment and Management

Facility: Community CYMHS
Date: 11/06/2020 Time:

(Affix identification label here)

URN:

Family name: Skywalker

Given name(s): Luke

Address:

Date of birth: 10/12/2003 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)

Identify factors precipitating recent serious violent incident at school, ongoing violence and aggression towards family members, and strengths/protective factors which maintain stability for Luke. Generate long-term management plan for violence.

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

Referred by school guidance officer (Virginia) due to behavioural difficulties at school, especially an episode of severe violence that resulted in suspension with consideration of expulsion. Suspension remains in effect at time of writing. Luke believes that the attack was warranted, and that he "didn't hit him [fellow student] that hard". Has received several suspensions in the past due to aggression towards other students, defiance, and truancy. School and Jenny (mother) report escalation over past 3 years, with increase in intensity in recent months.

Recently returned from placement with maternal uncle – exposed to illicit substance use and suspected trauma, which prompted the cessation of the placement. Currently experiencing symptoms consistent with trauma response – hypervigilance, sleep problems, exaggerated startle response, nightmares, anxiety. Luke has reported to Jenny a persistent fear of someone coming into his room to attack him since returning. Placement began 12 months ago, and ended 6 months ago. Sent on placement with Uncle due to increasingly aggressive behaviour at home and Jenny's difficulty managing this. Luke's aggressive behaviour at home is primarily targeted at Mindy (younger sister, 14 years old, intellectually impaired) and, to a lesser extent, Jenny.

Consumed alcohol and marijuana while at Uncle's. Continues to drink alcohol.

One episode of care with CYMHS (Luke aged 9). Previous diagnosis of ODD. Prescribed Risperidone (1mg) from ages 9 to 12, and Lovan (20mg) for 10 weeks. Limited effectiveness due to poor adherence to treatment. Previous treating team queried an ASD diagnosis, but ultimately conceptualised his presentation as a function of emotional neglect from family members/carers using illicit substances. Paediatrician assessment previously booked but not kept. Symptoms prompting referral for assessment included disinterest in socialising, limited facial expression, rigid and concrete thinking, and social inappropriateness.

Prejudicial previous family environment. Exposure to DV at home prior to death of Barry (Luke's father, died when Luke was 3 years old), likely lack of clear and consistent boundaries, financial stress, several notifications of concern made regarding child safety.

Historical difficulties with peer interactions and formation of friendships.

School reports ongoing concerns about anxiety (especially hypervigilance), empathy deficits, communication problems, behavioural problems (especially truancy and absconding from school), and distractibility.

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)

Violent incident at school recently – resulted in suspension pending consideration of expulsion. Luke approached a fellow student, Tyson, from behind (so that Tyson would be unaware of his presence), punched him in the back of the head, and kicked him several times in the stomach once he had fallen down. Luke then ran away before he thought any teachers would be able to catch him. Tyson was unable to stand after the attack and had to be taken to hospital to ensure no lasting injuries. Luke reports this act was retribution for Tyson "looking at me funny" two days prior in the context of ongoing conflict/bullying. No remorse for actions.

Escalation in violence and aggression at school and home over past 6 months since return home from Uncle's house. Intensification in escalation over past month.

Ongoing reactive violence and aggression towards Jenny and Mindy. Jenny often required to intervene in altercations between Luke and Mindy, which can prompt aggression from Luke towards Jenny (including yelling and pushing/hitting). Luke viewed this as a reasonable response to "annoying" and "stupid" behaviour from others. Aggression also involved punching walls and slamming doors. Resulted in change to accommodation.

History of bullying towards sister. Would tease her, yell at her, and throw things at her / hit her if she did not do what he wanted. Luke viewed this as normal for sibling relationships. Jenny reports Mindy is often the target for Luke's aggression when frustrated with school or with Jenny.

History of ongoing bullying and intimidation of peers (especially vulnerable students and female peers), including verbal and physical aggression. Began in pre-school, escalated through primary school.

Suggestion from previous episode of care with CYMHS that Luke uses aggression to control his environment in order to manage anxiety.

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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

- Disrupted attachment
- Exposure to domestic violence – emotional abuse, substance use, fam hx of DV
- Stressful current family situation
  - Jenny's anxiety and depression - ?impact on emotional resources available for parenting
  - Financial stress
  - Mindy – special care needs, context of single parent family with little external support
- Poor interaction with peers
- ?Hostile attributions to ambiguous social cues
- Empathy deficits, lack of remorse
- Communication problems
- Pro-violence attitudes
- History of antisocial behaviour (bullying, truancy, disruptiveness in class)
- Alcohol and substance use
- Poor frustration tolerance
- Possible ASD traits

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

- Limit setting
- Requests from others (e.g., Jenny asking Luke to do something)
- Thwarted attempts at control of environment
- Conflict with peers, including ambiguous social cues
- Subjective sense of injustice
- Mindy saying 'stupid shit'
- Availability of opportunity to attack without being caught or retaliated against.

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

- Possible trauma reaction to incidents at uncle's house.
- Possible modelling of dismissive/minimising attitude towards violence.
- Jenny experiences difficulty implementing consistent behavioural consequences and boundaries. Increasing fear of Luke due to increasing strength and size.
  - ?Numerous stressors detracting from Jenny's resources to manage Luke's behaviour (e.g., Jenny's own mental health, Mindy's intellectual impairment, pressure from school, family stressors).
- Current alcohol use with antisocial peers. Approx. once weekly, approx. one third bottle of spirits. Denies drug use.
- Lack of remorse.
- Continued pro-violence attitudes.
- Lack of insight into triggers in escalation of own anger, and reactions of others in social situations.
- Lack of social problem solving (including emotion regulation and frustration tolerance).
- Hypervigilant to aggression cues from others, lowered threshold for becoming aggressive.
- Possible mood disorder symptoms: ?anxiety ?depression.
- Bullying by peers.

- Investigated current and previous symptoms of psychosis, nil presence of same detected. Some features of sub-clinical paranoia in attribution style.
- Questioned Luke regarding plan to harm others at school and intent to bring weapons to school. Denied same.

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Foreseeable changes
- Expulsion from school.
- Return to school from suspension.
- Peer conflict (including with Mindy).

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

Luke is not an inpatient.

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

- Likes school
- Intelligent
- Enjoys gym
- Enjoys video games

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 Issues
- Assaulted peer in school yard (Tyson) – required hospital assessment
- History of aggression and violence at home and school
    - Escalating in frequency and severity over last 6 months

Predisposing Factors
- Intergenerational family violence
- Disrupted attachments (with possible lack of adequate care)
- Family stressors (financial, Mindy, Jenny's mental health)
- Family grief and loss
- Pro-violence attitudes
- Social skills deficits (including empathy deficits)
- Poor frustration tolerance/emotion regulation
- Hypervigilance to threat

Precipitating Factors
- Perceived slights against him in context of opportunity for attack (e.g. incident with Tyson)
- Negative interpretation of neutral or ambiguous social cues
- Perception of bullying
- Thwarted attempts to control environment
- Peer conflict
- Requests to initiate or cease an action
- Perceptions of injustice

Perpetuating Factors
- Lack of social skills
- Lack of insight
- Pro-violence attitudes
- Emotional reactivity
- Lack of emotion regulation strategies
- Emotional stressors (including conflictual home environment, possible trauma event and response, and hypervigilance to threat)
- Ongoing peer conflict – reinforces hostile attribution bias
- Unintentional reinforcement of violent behaviour at home
- Alcohol use
- ?Depression and anxiety symptoms (incl mood disturbance, sleep disturbance, and irritability)

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Protective Factors

- Intelligence
- Enjoys school
- Prosocial hobbies (gym and video games)
- Currently engaged with CYMHS
- Jenny's desire to support Luke and engage in intervention

High Risk Scenarios; Early Warning Signs; Foreseeable changes

- High Risk Scenarios
  - Any environment in which any of the following are present: access to potential victims (including vulnerable peers); exposure to ambiguous social cues; perception of bullying or injustice; limit setting; exposure to behaviour he finds 'stupid'/annoying.
- Early Warning Signs
  - Agitation; violence ideation; mood symptoms; emotional arousal; misinterpretation of social cues.
- Foreseeable Changes
  - Possible expulsion from school; return to school from suspension; peer conflict (including with Mindy); possible substance dependence.

Victim Group

- Mindy
- Jenny
- Similar age peers (perceived by Luke as bullying/judging)
- Any source of perceived antagonism or injustice

Severity of Violence

- Potential to be severe
  - Recent example of serious physical violence (opportunistic assault of vulnerable peer requiring hospital assessment)
  - Large size for age – capable of inflicting serious harm
  - Possible willingness to use improvised weapons

Imminence of Violence

- Next attack on Mindy – likely to be imminent
  - Ongoing access to Mindy
  - Ongoing presence of features of high-risk scenarios
  - Current high-stress context.
- Next attack on school peer – does not appear to be imminent
  - Currently suspended from school – however imminence of violence will likely increase when Luke returns to school

Conclusion

- Risk Status
  - Higher than general population due to: prejudicial family background; possible recent exposure to trauma; mood difficulties; lack of social skills; stressful home environment (lacks boundaries and clear consequences for actions).
  - Higher than community setting due to: recent severe violent episode; lack of remorse; ongoing pro-violence attitude; lack of insight; ongoing presence of features of high risk scenarios; access to vulnerable victim (Mindy).
  - Lower than inpatient setting, due to: absence of symptoms of psychosis, absence of specific plans to harm himself or someone else.
- Risk State
  - Lower than when he attacked Tyson due to lack of specific grievances with any peers.
  - Higher than 12 months ago (placement with uncle) due to: escalating aggression and likely trauma experienced during this placement.

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
Possible underlying ASD phenomena	Investigate ASD	Place on waitlist for paediatrician assessment, book in for interim psychiatric assessment. Determine whether a member of the MDT has the appropriate skillset to conduct a full assessment of ASD. If not, also provide the family with options for a full assessment by an NGO (if utilising a provisional in-house diagnosis based on ICD-10 or DSM5 criteria is insufficient for the treatment plan). Consider commencement of treatment targeting communication and emotion regulation and/or relevant referral options for this (e.g., private psychology).
Possible exposure to trauma	Investigate and treat possible trauma response	Focus on rapport building, investigate trauma events ongoingly (at Luke's pace), discuss and practice strategies for managing trauma response (e.g., grounding, mindfulness, breathing).

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High level of risk to Mindy and Jenny	Ensure safety of Jenny and Mindy	Ongoing Case Management, monitor situation for requirement for notification of concern re child safety (for Mindy), form safety plan with Jenny to ensure safety of herself and Mindy (e.g., early intervention, setting boundaries safely, calling the police if required), discuss plan with Mindy re how to alert Jenny to threats to her safety.
Disrupted attachment style	Improve attachment	Rapport oriented therapy initially with Luke, attachment based therapy with Luke, family therapy, parenting skills intervention for Jenny (e.g., Circle of Security, Triple P).
Possible underlying mood disorder	Clarify presence of mood disorder	Conduct diagnostic assessment for mood disorders, begin treatment for anxiety and depression (e.g., CBT, IPT, ACT).
Lack of structure in home environment, family stressors	Provide support to Jenny	Provide information re services to maintain Jenny's mental health (e.g., MHCP), referral to parenting skills programs (Circle of Security, Triple P), provide information regarding carer support services (esp. for Mindy) and financial planning support (possibly NGOs).
Alcohol use	Reduce alcohol use	Motivational interviewing, consider AODS referral if Luke agreeable.
Lack of social skills	Enhance social insight and problems solving; Build empathy for others	Social skills group, focus on social skills in 1:1 Case Management (e.g., IPT, chain analyses), psychoeducation (e.g., formulation feedback), insight oriented therapy (e.g., focus on early warning signs, triggers, and intervention strategies), empathy building/perspective taking.
Pro-violence attitudes	Reduce pro-violence attitudes	Social skills training, empathy building/perspective taking, cost/benefit analyses, discussing personal consequences of violence (e.g., risking jail time).
Lack of insight into own emotions	Enhance insight	Initially focus on rapport building, insight oriented therapy, emotion focussed therapy.
Upcoming foreseeable changes	Contingency plan for expulsion, return to school, and peer conflict.	Identify and discuss upcoming risks with Luke (and Jenny, if appropriate), and brainstorm strategies to avoid or mitigate these, consider graduated return to school, establish plan for managing conflict at school and home (e.g., identifying safe place to go, identifying safe person to talk to prior to becoming aggressive).
Poor communication between stakeholders	Improve communication between stakeholders	Conduct stakeholder meeting (between Jenny, school, and possibly Luke) to discuss early warning signs and triggers for Luke's aggression, agreed management strategies, and set up regular communication.
Protective factors	**Clinical goal**	**Preventative strategies, interventions and involvement of other service providers**
Likes school	Maintain engagement at school	Develop collaborative relationship between Luke and school staff, establish reward plan for non-violence at school, collaborate with school to set up adaptive coping strategies for Luke (e.g., safe people and places to go to when he gets angry).
Intelligence	Provide opportunities for Luke to lead intervention process	Maintain open and transparent therapeutic approach, identify and praise Luke's demonstrations of intelligence and adaptiveness – build identity as someone who solves problem with his brains rather than his fists, encourage Luke to identify his own goals for his aggression and associated strategies.
Gym	Maintain physical health, establish adaptive and safe ways to regulate aggression	Encourage continued engagement with gym, consider engagement with mentor who can teach Luke to express aggression safely and adaptively (e.g., martial arts teacher, football coach).
Video games	Establish as an alternative strategy to aggression	Incorporate video games into plan for alternative coping strategies for managing violence risk.

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

Jenny (Mother)

School guidance officer (Virginia)

CIMHA – all clinical records

Interview with Luke

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)

The report is to be discussed with Luke's treating team at the next care review.

Information to be shared with Jenny (and school, if appropriate) regarding Luke's risks, the clinical explanation for these, treatment rationale, safety plan, and resources to maintain personal mental health (and that of Mindy).

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

Clinician's name (please print):	Designation:	Signature:	Team:	Date:	Time: