

Assessment and Management of Risk to Others

Guidelines and Development of Training Toolkit

2006

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Foreword

The Guidelines for Clinical Risk Assessment and Management in Mental Health Services (Ministry of Health, 1998) established the framework for how clinicians assess and manage risk within general adult mental health services. It was the forerunner to this present document and should be acknowledged for its innovation in providing strong guidance in standardising the approach to clinical risk assessment and management across the broad spectrum of mental health settings and disciplines.

This guidelines document seeks to take this approach several steps further. It reviews the 1998 guidelines, examines current literature, and defines the competencies required for competent assessment and management of risk to others. It also lays the conceptual foundations for a toolkit which can be used for training and service development in mental health settings. Training Resources (a Trainer Manual and a Trainee Workbook) are also available to complement these Guidelines.

To mitigate challenges to clinical practice a strong set of standards, a sound training regime and quality auditing programme is required. With this in place, consumer outcomes are optimised, families and the public in general will have more confidence in adult mental health services, and staff will feel more comfortable in their practice.

I want to acknowledge and thank those who have contributed to the review of the guidelines and the development of the training toolkit. Their passion and expertise have been hugely valuable in creating what I believe is an excellent tool for practice.

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Deputy Director General
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Purpose

People who require the care and support of mental health services have a range of needs and challenges. Serious mental health problems can result in various risks of harm, one of which is a heightened risk of violent behaviour. Whilst this risk is present in a minority of mental health consumers, failure to identify this risk and work with the consumer and their family/whanau can have catastrophic results. Risk assessment and risk management are, therefore, in the therapeutic interests of all concerned, most especially the consumer. They are vital therapeutic processes that support recovery by keeping it free from violence.

In recent years, risk assessment and management processes have been afforded greater organisational priority, sometimes to the frustration of mental health professionals who feel under increasing pressure to comply with yet further clinical directives. Often this emphasis of risk occurs without the provision of additional resource. Balance is important if tools generated by projects such as the current one are not to add to this sense of frustration. Risk assessment and management are just one part of the broader clinical process, albeit an important component. The risk assessment and management plan does *not* replace the need for broader care planning. The aim of this project is to develop a toolkit, which reflects the activity of competent practice that is already occurring in many mental health contexts, in a form that can be incorporated into pre-existing care plans in services with less well-developed risk assessment and management processes.

Violence involves not just individuals, but families, communities and societies. Understanding the pathways to violence and the process of recovery from violent acts necessarily involves an appreciation of these different perspectives, each with its own validity. Some perspectives focus on the rights of the consumer; others emphasise the impact on victims. At times, these perspectives seem to be in conflict. The nature of violence and its consequences often lead to avoidance rather than confrontation of certain issues. This is reflected in the language that is used in talking and writing about violent incidents. Each group uses different language to address its perspectives and tasks. It would be surprising indeed if everybody were satisfied with the language used to discuss human violence in this document. For risk assessment to be done properly, the language used should not avoid issues. Violent behaviour is just that, violent; to call it anything else is to distort its true nature. However, some introductory comments about the perspective taken here may be useful.

We believe that risk assessment is best approached as a therapeutic task (Mullen, 2000). It is a process of clinicians working with and alongside, the consumer. Being able to talk with the consumer about issues of risk is central to successful recovery, which requires safety for all involved to be successful. Clinical language can sometimes make this process appear too clinical, so that risk assessment becomes something that is done to the consumer. This is not our intention. Risk assessment should not be an accusatory process; the language used is important in respecting various perspectives. The purpose of risk assessment is to limit, as much as possible, adverse outcomes for all concerned. Ultimately, risk assessment has to include understanding of the personal and cultural values, experiences and influences that shape a person's needs, behaviour, and mental health. Risk assessment requires a joint development of narrative so that understanding can be shared and risk reduced. We advocate addressing the issues within a therapeutic relationship, so that issues of risk become a valid topic of enquiry for the mental health worker, as part of the recovery focus.

The purpose of this document is to review risk assessment and management approaches to violent behaviour by mentally ill people who are in contact with mental health services, and to develop a framework for clinical risk assessment leading to risk management, which will be applicable to mental health settings.

The risk assessment guidelines produced by the Ministry of Health in 1998 were clear, simple and straightforward, and touched on the key clinical and cultural issues relevant to this area of clinical practice. They were practical and broadly applicable. However, we know little about how well these guidelines have been implemented, how thorough risk assessment practices are, and how available training is to assist mental health workers to practice well and safely. Good practice requires clarity of standards and processes. Consumers of mental health services have a right to expect this.

The terms of reference for this review are as follows.

1. To review the 1998 guidelines.
2. To survey current national and international practice in violence risk assessment and management for people with serious mental illness who are in contact with adult mental health services.
3. To define competencies relevant for different mental health practitioners in violence risk assessment and management.
4. To lay the conceptual foundations for a violence risk assessment toolkit that can be used for training and service development in mental health settings.

This review is aimed at guiding the development of policies, procedures, training and audit mechanisms for the assessment and management of risk of violence. This document should be read in conjunction with the training toolkit. We aim to be real world, acknowledging the practical realities of delivering mental health care, but not compromising the standard we believe represents good clinical practice.

Risk assessment and management are central to good recovery-based care. Simply delivering good care without explicit consideration of risk issues is not adequate and may miss key issues of preventable risk. Both risk assessment and management are inextricably linked within the therapeutic process.

Introduction

An important reference point for the current project was the document entitled *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (Ministry of Health, 1998). The working group on that project, chaired by Dr Nick Judson, produced a set of guidelines that conveyed the general principles underpinning risk assessment and management. As laid out by the then Director of Mental Health, Dr Janice Wilson, the guidelines were produced in recognition of the fact that many services and clinicians were in the process of developing protocols and guidelines for practice. The 1998 guidelines were designed to facilitate that process.

The 1998 guidelines were well-constructed. They are consistent with the current thinking about risk assessment and management.

There are differences in the terms of reference between the 1998 and the 2004 project. First, the Ministry of Health was explicit that the working group should confine the current project to the risk assessment of violence to others posed by people with serious mental illness who are in contact with adult mental health services, as opposed to broader risk concerns, such as suicide.

More specifically, in keeping with our brief to provide a broadly applicable set of tools for risk assessment, we decided against the inclusion of instruments or approaches that target special types of offending such as sexual offending. Rather, it was our aim to provide a framework for assessing risk that would be applicable across the spectrum of mental health services and clients that present at mental health services. For example, the vast majority of sex offenders are not mentally ill and do not, therefore, usually come to the attention of mental health professionals unless referred in the context of legal proceedings. Their risk for recidivism is usually dealt with via professionals specialised in the field of sexual offending. As the base rate for offending is usually high in this group, actuarial tools, such as the *Sex Offender Appraisal Guide* or the *Rapid Risk Assessment for Sexual Offence Recidivism*, may be appropriate to use.

There are, however, some individuals who come to the attention of mental health services who, in addition to other risk behaviours, also engage in sexual offending. As is true for physical violence, certain symptoms of mental disorder that lead to impulsive or irrational actions may also lead to inappropriate or violent sexual behaviour. For this group of sex offenders the use of actuarial scales would not be useful as they tend to have a low baseline of sexual offending. Instead, the framework for risk assessment that we propose here for the generic toolkit would be preferable. It could be augmented by the use of the *Sexual Violence Risk 20 (SVR-20)* guide (Boer, Hart, Kropp, & Webster, 1997), which is akin to the *HCR-20*. In fact, half of the items in both scales are identical and the remaining items differ in that they prompt specific inquiry into previous sexual offending. The framework that we propose here mandates such detailed inquiry into past violence and offending. Thus, we feel confident that this process of risk assessment provides a very useful framework for the risk assessment of the group of sex offenders who are likely to be seen in mental health settings.

Similarly, we decided not to explicitly address the special issues concerning risk assessment and management for intellectually disabled persons. However, the overall framework provided here is also applicable to this population. The current thinking in the intellectual disability field is that a guided clinical judgement approach is the most suitable as it allows for individualised assessment and

formulation (Fraser, 2002). Actuarial risk assessment approaches have at this time little application to persons with intellectual disability, due to a lack of studies regarding actuarial predictors that use intellectually disabled subjects and base rates for offending in intellectually disabled populations. Furthermore, since risk assessments for persons with intellectual disability are usually conducted in the context of determining clinical pathways and ongoing risk management in the community or community-based settings, an individualised approach is vital. Our overall framework, which derives risk management from individualised assessment and formulation according to the principles of guided clinical judgement, is fully applicable to this population. However, certain aspects of risk assessment and management may differ to accommodate the special features of persons with intellectual disability, for example, the balance of self-report information with observation assessments in different circumstances and a stronger focus on behavioural rather than cognitively based management strategies. Furthermore, the built-in adaptability of the model to different organisational contexts is important, as intellectual disability services also deal with varying levels of staff competencies and training, and resource and service configuration problems, as well as interagency cooperation and coordination issues.

The second difference in the terms of reference from the 1998 guidelines was to place greater emphasis on the translation of general principles into practical tools. Although it is not part of the current project, the material produced by the current group should form the content for courses that would be part of a national training strategy.

Therefore, the aim of the current project is to review the guidelines, along with national and international examples of best practice, to produce a toolkit that has immediate practical value and that will be applicable to a range of clinical settings. Our task, therefore, is to facilitate the transition from the general principles developed by the previous working group to practical application.

Some mental health services are well down this pathway and already have in place a series of protocols and practices concerned with clinical risk assessment and management. However, the concern of the Ministry of Health is that such an advanced level of development of both protocols and practice is not reflective of the state of practice across all mental health services in New Zealand. For this reason, the purpose of this review and toolkit is not so much to challenge those services that are already operating at an acceptable level or better, but to provide explicit guidance for those services that are in greater need.

The Ministry of Health also required that the toolkit should be applicable to mental health professionals working in different settings: forensic and general adult; acute and non-acute; in-patient and community; and should be sensitive to differing cultural contexts. This provides a considerable challenge because of (1) the potential variation in contextual risk factors; (2) the likely wide variation in levels of resources, skills and experience across and within settings and professions; and (3) the differing rates of violent behaviour.

The consensus view of the working group was that to achieve the practicality criteria, we would have to address issues of both the content and form of the toolkit.

First, with respect to content issues, the working group's view is that to achieve greater clinical utility, it is necessary to take a fresh look at the risk factors generally listed in risk assessment approaches. Specific details around some

of these risk factors are often missing or underplayed. For example, we agree with the 1998 document that delusions should be considered when undertaking a risk assessment. However, many people have delusions and are not violent. Also, many people who have delusions and are violent *on some occasions, are usually not* aggressive and violent, even though their delusional system may persist. So, what is it that leads people with delusions to act violently on some occasions but not others? A framework that addressed these sorts of issues that consumers, families and mental health workers have to grapple with in day-to-day situations would be of real clinical value.

Second, the form of the toolkit is also considered to be critical in terms of the success of the current project. A very detailed set of guidelines might safeguard against missing important pieces of information but might be counterproductive to the actual use of the toolkit, as mental health workers, like any other clinical group, have a natural resistance to processes that appear complicated and onerous. This implies that the challenge is to produce a toolkit that is simple without being simplistic.

The working group also wanted to avoid producing a risk assessment process that is esoteric, ivory towered, or biased towards dealing with extreme examples of very high-risk people. Rather, we are concerned with the core day-to-day work of the majority of mental health workers. To this end, we encourage the view that *part of risk assessment* is implementing a reasonable standard of clinical care that helps prevent violent acts by those with mental illness. This contrasts with usual emphasis on the predictive aspects to risk assessment, a theme to which we will return when we consider what can be learned from homicide inquiries.

Five principles guided our efforts.

1. **Simplicity** – The conceptual framework for violence risk assessment and management had to be simple enough to be easily remembered. If it cannot be recalled and have immediate meaning, there is no real hope that mental health workers will use it in the stressful environment of day-to-day work.
2. **Practicality** – The framework had to have sufficient specific detail to be practical, without being so inclusive that it is overbearing or unwieldy.
3. **Validity** – The content of the toolkit should contribute to care plans that experienced and expert people in various mental health disciplines will recognise as being central to the task.
4. **Flexibility** – The framework should be adaptable for different settings (e.g., forensic versus general adult) and be able to define levels of practice by role, professional development and discipline.
5. **Sensitivity** – The framework should attempt to recognise the multiple perspectives that are brought to bear on the issue of interpersonal violence, including consumer, family, community, cultural and victim's viewpoints.

The current document will be organised into four main sections. Part 1 outlines the model of risk assessment we propose to follow, followed by a review of current literature, guidelines and protocols used in various geographical regions. Part 2 addresses the New Zealand context more specifically by considering cultural issues and relevant legislation, and outlining professional competencies. Part 3 addresses in more detail aspects of risk management in terms of current

best practice; this focuses on the platform of good clinical care in general terms, in recognition of the important role of competent clinical care plans in preventing violent incidents. This best practice should reflect the transition into the risk management phase from the risk assessment process. Part 4 focuses on practical issues more specifically related to risk assessment processes, including potential practitioner resistance to violence risk assessment and the introduction of the conceptual framework used to develop the violence risk assessment and management toolkit.

Part 1: A Review of Current Literature and Practice

Models of Risk Assessment

At the outset, it is important that we are clear about the model of risk assessment and management we wish to convey, for the literature in this area is filled with controversy regarding differing methods of risk assessment. There are two main approaches to assessing the risk that people pose: clinical and actuarial. Each has its proponents in the literature and debate has at times been heated about what method to use when, and why. We will not repeat these controversies, which have to a considerable degree been misunderstandings of the relative merits of each technique and the settings in which they are to be used. What has emerged in recent years as being the best practice standard for risk assessment in mental health services is the process of structured clinical judgment, a conclusion we support.

What do we mean by these terms? Actuarial risk assessment tools are structured instruments that record information about a person and their past behaviour, and use this information to assign the person to a category of risk of performing that behaviour in the future. They are statistically based, and they have largely been developed on offender or forensic populations. They are very useful tools in offender populations when the rate of criminal behaviour is high, and in that context they may be helpful in identifying subpopulations of offenders at higher or lower risk of re-offending. They have some place in forensic settings, where there is overlap with offender groupings. There, actuarial techniques may help to guide or contextualise clinical risk assessment. Actuarial techniques have little or no relevance in general mental health settings where the rate of criminal offending is much lower.

Clinical risk assessment is a different activity. Instead of relying on statistical associations and comparing the person to a sample group, clinical risk assessment works by carefully understanding the individual's background, past behaviour, and current experience and context, to understand the patterns of behaviour, context and mental state that may give rise to risk to others. It is a narrative-based or integrative, rather than a statistical, process. Constructing a possible understanding of why this person may be at risk of behaving violently opens the door to identifying management strategies for decreasing risk, and enhancing the person's well-being and recovery. This individualised process should be universal in mental health services, and is the basis of the structured clinical judgement approach we are proposing in this document.

Guided or structured clinical judgement uses elements of actuarial techniques to contextualise the risk, combined with narrative or formulaic approaches to define the relevance of risk factors, to focus attention on interventions based on risk factors that can be altered. This has particular application to forensic populations and higher risk general mental health populations.

Literature Review

The literature on the generic subjects of risk assessment and risk management is prolific. A search of these subject headings on Medline alone uncovered 278,694 publications. This was limited to 44,329 publications by entering 'mental health services' adjacent to the generic terms. However, the intent of this literature search was specific. The aim was to limit the review to international best practice

initiatives guiding risk assessment of violence. Therefore this process was further refined through the use of the key words 'framework', 'guidelines', 'model', 'system', 'policies', 'best practice', 'education', 'education toolkit' and 'education resource kit'. This process was undertaken on Medline (96 publications), PsychInfo (66 publications), Embase (50 publications) and the Cochrane library (no publications). A perusal of the titles of these publications and a subsequent critique of selected abstracts obtained less than 20 relevant articles.

The majority of these articles are not specific service practice guidelines, except Kelly, Simmons, and Gregory (2002) who outline the Forensicare community forensic mental health practice model of risk assessment and management used in Victoria, Australia. Rather, the literature discusses guiding principles that any service should consider in the development of a risk assessment process. Three possible approaches to risk assessment of violence are articulated – unstructured clinical judgement, actuarial risk assessment and structured clinical judgement – as introduced in the preceding section.

Unstructured clinical judgement involves decision-making by clinicians without reference to literature that informs the decision-making. This approach is criticised in that decisions are based on opinion, which is subjective, idiosyncratic, and potentially biased. Furthermore, there is little evidence of the accuracy of the decisions made (Doyle & Dolan, 2002; Hart, 1998). Although some individual clinicians may possess expert skills that allow them to practice this method, accuracy and consistency are improved by a more systematic approach.

Actuarial risk assessment attempts to predict the likelihood of future violence. The actuarial approach arrives at a probabilistic statement that an event will or will not occur, based on fixed and explicit rules that focus on the presence of a small number of static risk factors that have an association with violence (Bauer, Rosca, Khawalled, Gruzniowski, & Grinshpoon, 2003; Douglas & Kropp, 2002; Hart, 1998). These predictions are based on population research, which determines the likelihood of specific classes of people being violent (Bauer et al., 2003). Actuarial risk assessment assigns an individual to a group that has a certain degree of risk for future violence. Actuarial risk assessment cannot say whether this individual will or will not manifest that risk. Therefore, actuarial risk assessment provides passive prediction, which is of limited practical clinical use (Hart, 1998).

The approach to risk assessment of violence favoured in the literature involves structured clinical judgement. Decision-making is based on literature that reflects current theoretical, clinical and empirical knowledge about violence. It emphasises the ongoing, changing nature of risk, as opposed to determining a probabilistic statement. In doing so, it shifts the emphasis from prediction to prevention. There is evidence that this is superior to actuarial techniques alone (Douglas, Ogloff, & Hart, 2003). This process constructs an understanding of why, and how, a person may be at risk of becoming violent, which can be used to determine management strategies to prevent it.

The literature highlights a series of steps to be taken in the process of risk assessment in accordance with structured clinical judgement. These are as follows.

1. Gather comprehensive information from a variety of sources including the mental health consumer, their family/whanau, other treatment teams and historical records (Miller, Tabakin, & Schimmel, 2000).

2. Detect evidenced-based risk factors (Miller et al., 2000). Standardised assessment instruments designed for predictive purposes may assist this process by providing a check-list of the risk factors that need to be considered (Bauer et al., 2003; Douglas & Kropp, 2002; Stein, 2002).
3. Distinguish between risk factors that are static and cannot be altered, and those that are dynamic, which, if targeted, may accomplish a reduction in violent behaviour (Borum, 1996). The MacArthur Risk Assessment Study provides an approach to this task by dividing risk factors into four domains: personal factors (e.g. demographic characteristics, personality and cognitive ability), historical factors (e.g. history of violence and crime), contextual factors (e.g. perceived stress, lack of social support, and access to the means to cause violence), and clinical factors (e.g. symptoms, patterns of illness, substance abuse and treatment compliance) (Monahan et al., 2000).
4. Formulate a risk assessment based on clinical judgement, which considers contextual risk factors that increase or reduce risk (Douglas et al., 2003).
5. Team decision-making, which integrates multiple perspectives, is preferable during this formulation (Bauer et al., 2003; Doyle & Dolan, 2002; Murphy, 2002).
6. Document the risk assessment process (Miller et al., 2000).
7. Develop a risk management plan that flows from the formulation of risk (Douglas & Kropp, 2002). This plan should be a collaborative exercise between the mental health consumer, the clinician and the family. The management plan should address reducing risk factors, and developing protective factors (such as stress management strategies, coping skills, consumer strengths, communication skills and knowledge of early warning signs). It should also include a crisis plan of what to do in times of heightened risk (Kelly, Simmons, & Gregory, 2002).
8. Risk assessment is an ongoing process, not a one-off event. Therefore, the communication of information is crucial (Doyle & Dolan, 2002). A brief risk statement, which serves as an alert, should be undertaken and appear in written and electronic files (Stein, 2002), and be regularly updated.

1998 Guidelines, Risk Assessment Proformata, and Benchmarks

Review of the 1998 New Zealand Guidelines for Clinical Risk Assessment and Management

The 1998 guidelines set out a structure to think about issues of risk assessment, which involved steps of information gathering, and formulation and construction of a risk management plan. It listed risk factors that need to be considered in information gathering and integrated during the risk formulation process. Very usefully, it advised applying the same overall formulaic approach to risk assessment regardless of the type of risk involved. It considered risk to self (both suicidal and self-neglect) as well as risk to others.

The 1998 guidelines aimed to be, and succeeded in being, brief, readable and practical. Indeed, a policy on risk assessment based on that document would still develop a good and comprehensive system that contains all the key

elements of risk assessment. It sets risk assessment in a context of overall care planning, cultural assessment and culturally aware implementation. It links to key issues in law that need to be considered and emphasises the necessity for clear documentation and communication of risk information. The bibliography is intended to be practical and relevant, and is based on the considerable experience of the authors of the guidelines who were experts in the field. This is an architecture for thinking about risk that we share.

Since the 1998 guidelines were written there has been much change, including:

- considerable development in risk assessment techniques;
- an increasing awareness that it is only ethical and appropriate to perform risk assessment if it is done within the context of subsequent and concurrent risk management;
- increased awareness and understanding of the balance of responsibilities for consumer, family and community involvement.

Further, key service philosophies have developed, including the centrality of recovery and specific cultural competencies required of mental health workers. Suicide assessment now has its own set of guidelines, as do compulsory treatment and information sharing. Further, the process of guideline production now has a specific methodology, which requires a systematic approach to gathering evidence from literature and from practice standards review. The output needs to be subject to peer review and feedback, and to have clear links to practice competencies and service delivery. The 1998 guidelines fell a little short of the standards expected of clinical practice guidelines. However, we could find few national guidelines of similar quality readily available in the world literature, underlining the value of the previous efforts of the working group.

Thus, while the core principles of the 1998 guidelines have stood the test of time, the context and the standards of delivery need to be informed by our current understanding of techniques of structured clinical judgement, which has been defined more clearly in recent years.

Review of National and International Risk Assessment Proformata

In line with the objective of producing a toolkit with practical relevance, a review was conducted of documents concerning risk assessment policies, procedures, and proformata from various national and international sources. Our objective was to use this information base to delineate a minimum adequate architecture for practical risk assessment documentation. To have face validity, the basic structure of the toolkit should, at a minimum, be consistent with the main components on which the risk assessment tools used in reputable centres are based.

A scientific and systematic sampling procedure was not practicable for this task. Instead, the working group used knowledge of, and contacts within, various centres of excellence within New Zealand, Australia, U.S.A., Canada, and the United Kingdom, to access a range of relevant documents. Sampling involved both general adult and forensic facilities and systems. Although this information base is knowingly subject to selection bias, the method was felt to be acceptable for a process of setting benchmarks.

A review of the various proformata that we received revealed several commonalities.

- They were usually based on three generic tasks – the gathering of relevant information, risk formulation and risk management.
- They all directly addressed factors that increased contextual risk (risk factors).
- They often directly addressed factors that lowered risk (protective factors).
- The majority required those completing the forms to provide a categorisation of the risks that the consumer was felt to pose at that time.
- The majority of locations used a tiered approach across the general adult and forensic service interface, with forensic services typically including a standardised instrument (generally the HCR-20) in the local pro forma.
- The majority addressed the different dimensions of risk (i.e. imminence, likelihood, severity and frequency).

However, various aspects of the design and content of the various proformata also showed significant geographical variation, including the following.

- Most included risk factors that have empirical support, at least to some extent, but some did not.
- A small number included procedural guidance as to when it was appropriate for the forms to be completed, by whom, and where they were to be stored.
- Format varied widely. In general terms, some used a tick-box approach, some were based mainly on prose (text boxes), and some used a combination of these two methods.
- Length also varied widely. The briefest pro forma was two pages; the longest was 13 pages.
- The amount of detail varied considerably. Some forms asked a few general questions that required written responses, while others appeared very detailed, using small font size and large amounts of explanatory text. However, it cannot be assumed that detail and length are necessarily correlated with quality. Some institutions that are well-recognised for research and clinical excellence used proformata that would be positioned at the simpler end of the scale.
- Some forms explicitly asked for information about violence that had not attracted the attention of the criminal justice system, while others placed greater emphasis on criminal offending.
- Some integrated risk assessment with risk management, while others did not. After the gathering of information and the formulation of risk, some risk assessment processes simply stopped. Others required the development of explicit risk management plans on the basis of the formulation.
- Some were designed so that they could be updated, while others were based on one use only formats, which has implications for the repetition of material.

- Some used prompts and reminders to provide guidance about what was required in sections allowing descriptive accounts, while others just had subheadings and an area to write, but no prompts.
- Some included lists of people to be contacted in certain situations (e.g. people to be informed if the consumer was absent from a psychiatric hospital without leave), while others did not.
- Some forms included review dates and outlined processes for updating the relevant forms.
- Some included a definition of respective clinical roles and tasks for the multidisciplinary team.
- A few included a visual or diagrammatic overview of the risk assessment process, although most did not.

Review of the various proformata revealed several tensions inherent in the design process. First, there was a clear tension between (1) using comprehensive but longer risk assessment pro forma, with the accompanying likelihood of increased resistance to completion of the forms, and (2) using briefer forms, which might result in greater compliance but might also be open to criticism for being too restrictive.

Second, there was a tension between an absence of structure (and therefore reduced guidance), and proformata with high levels of structure, which provided guidance but a relatively restricted opportunity to make unstructured contributions or record idiosyncratic detail.

Third, the lack of integration of risk assessment information with risk management approaches was notable in some cases. Some restricted the role of risk assessment solely to identification of risk, while others were more direct in linking the information gained in the risk assessment process into risk management.

Finally, although this overview is explicitly of risk assessment guidelines with a view to producing risk assessment proformata, we were also sent many different local versions of policies related to the risk assessment and management process. This emphasised the point that risk assessment is only likely to be effective if the process is embedded in appropriate service structures and services. The following policy components were reasonably consistent across different geographical locations.

- A statement that risk assessment and management is a core clinical responsibility and not an optional practice.
- A statement outlining who should comply with the risk assessment and management process (i.e. professional responsibilities).
- A statement about who the process applies to (i.e. who should undergo the process).
- A statement about who is responsible for making sure that the process is carried out competently.

- A statement concerning the importance of recognising cultural factors within the process.

Lessons from Inquiries

Inquiries into acts of violence by people in contact with mental health services have performed multiple functions: to determine what occurred; to see if there are lessons to be learned about local or systemic practice; and to determine if there were issues regarding competency or capability of the staff involved (Buchanan, 1999).

Inquiries are very much a part of the British and New Zealand mental health systems. Whilst there is a perception that these processes bring a culture of blame, and staff members being inquired into feel scrutinised, so important are the issues that they are now a mandated process following any serious or sentinel event. Such inquiries are an opportunity to answer the concerns of consumers, family and victims, for service improvement, and for development of corrective actions that are found necessary.

So, what have inquiries in general found? Reed (1997) summarises the findings of inquiries in England and Wales as:

- a failure of mental health workers to take the reports of others seriously;
- undue emphasis on a narrow concept of liberty;
- failure to use compulsory treatment;
- tendency to be cross-sectional and not take on board past history; and
- failure to share information.

A review of inquiries in New Zealand found very similar problems here (Simpson, Allnut, & Chaplow, 2001). Inquiries generally found training and resource deficiencies to have contributed to poor outcomes, as well as service structure and coordination shortfalls. Individual clinicians have only been seriously criticised in approximately 20% of inquiries.

A different way of looking at these incidents was developed by Munro and Rumgay in their review of 40 inquiries in the United Kingdom (Munro & Rumgay, 2000). They asked whether the tragedies were best seen as predictable or preventable: by predictable the authors meant those cases where high-risk issues were evident to all; preventable referred to cases where, had the person received a reasonable standard of clinical care, regardless of whether the person had been assessed as high risk, the tragedy would have been, in all likelihood, averted. They found 27.5% to be predictable and 65% preventable. In New Zealand, similar findings were obtained by Simpson *et al* (2001). Thus, much better results could be achieved across the sector just by implementing best practice standards in mental health care.

Inquiries suggest the top priorities for improving our care to be:

- thorough assessment and monitoring of patients, which includes a longitudinal understanding of their needs;
- decisive intervention in high-risk situations;

- knowledge of the process of risk assessment;
- accurate and full record keeping with clear communication between clinical staff;
- taking seriously the concerns of family and whanau;
- recognition of and attention to situations of vulnerability.

Therefore, inquiries remind us that attention to the provision of good quality, comprehensive care significantly reduces risk and that specific risk-focused procedures further improve outcomes.

Part 2: The New Zealand Context

Cultural Guidelines

Cultural Issues in Psychiatry

The delivery of mental health services has been significantly shaped by the influence of globalisation. Our communities are no longer monocultural, but increasingly melting pots of different ethnic groups and cultures. Awareness regarding the complexities of addressing the mental health needs of culturally diverse populations has steadily increased. It is now well recognised that culture can influence mental illness by defining normal and abnormal, implicating causal factors, influencing clinical presentation and determining when, why and how people access help and what type of help is considered appropriate (Bhugra & Bhui, 1997). This has prompted the American Psychiatric Association to formally acknowledge the impact of culture and ethnicity on psychiatric diagnosis and treatment, and to caution that misinterpretations may occur if these issues are not appropriately considered (American Psychiatric Association, 1994). There is now an expectation that mental health services will be responsive to the needs of the communities served and that in the context of multiculturalism, mental health workers will demonstrate cultural competence.

This increased awareness of the cultural needs of mental health consumers extends to the clinical violence risk assessment process: competent violence risk assessment must address relevant cultural factors that may impact upon the therapeutic relationship, including pathways to violence and subsequent recovery.

Māori and Mental Health

In New Zealand, Māori have paved the way for a society better able to accommodate and celebrate cultural diversity. The journey has been fraught with difficulty and beset by obstacles and hazards, but it has resulted in widespread recognition of Māori aspirations, values and perspectives. Today all government documents acknowledge the unique relationship between Māori and the Crown under Te Tiriti O Waitangi and the obligations of the Crown because of this partnership.

In terms of mental health, the government and the Mental Health Commission have recognised the disparities in mental health status between Māori and non-Māori and are committed to reducing inequalities (Mental Health Commission, 1998, 1999; Ministry of Health, 1997a, 2002). Māori have substantially higher first psychiatric admission and readmission rates compared to non-Māori. Māori are also over-represented in drug and alcohol services. Drug and alcohol abuse and psychosis, especially schizophrenia, are the main reasons why Māori are admitted for psychiatric inpatient treatment. Māori tend to access care through different pathways compared to non-Māori. Māori present to mental health services at a later stage of their illness and tend to be more seriously ill. Referrals from law enforcement agencies and use of compulsory assessment and treatment orders are significantly higher for Māori than for non-Māori (Te Puni Kokiri Ministry of Māori Development, 1996). Māori are over-represented in forensic services comprising 50% of the total inpatient population (Ministry of Health, 2001b) and prison where the rates of serious mental illness are higher than community levels (Simpson, Brinded, Laidlaw, Fairley, & Malcolm, 1999). The clear disparities between Māori and Non-Māori have led to increased awareness and acceptance of the need for mental health services to be responsive to the cultural needs of Māori.

Māori and Risk of Violence

Patterns of service utilisation for Māori prompted the Mental Health Commission to comment, 'Māori are viewed and treated as being more dangerous than non-Māori' (Mental Health Commission, 1998). If this is true then the criminalisation of people with serious mental illness who commit acts of violence in the context of their illness is likely to disproportionately affect Māori, contribute to Māori imprisonment rates and seriously hinder Māori ability to engage in a recovery process. Consequently, Māori have a vested interest in the development of a toolkit that aims to improve mental health workers competency in assessing and managing risk of violence within the context of good clinical practice.

Good Clinical Practice from a Māori Perspective

Good clinical practice is the key to effective risk assessment and management, and for Māori this must incorporate cultural dimensions and perspectives to be successful. This is acknowledged by the government in the National Mental Health Standards and by the Mental Health Commission in their publication, *Recovery Competencies for New Zealand Mental Health Workers* (Mental Health Commission, 2001c; Ministry of Health, 1997b; O'Hagan, 2001). Three principles that underpin good clinical practice from a Māori perspective have been described by Professor Mason Durie and are widely supported by Māori (Durie, 2004). These include (1) the principle of indigeneity, which acknowledges the determination of indigenous peoples to retain their unique identity, avoid assimilation and exercise a degree of autonomy; (2) the principle of clinical expertise, acknowledging the right of Māori to expect the very best evidence-based treatment or therapy available; and (3) the principle of cultural competence, which focuses attention on the ability of mental health workers to be competent at the interface between their own culture and the culture of others. Historically, cultural and clinical expertise have been polarised, although there is now greater commitment and focus on the integration of these principles. This is particularly important in the assessment and management of risk for violence, because an integrated approach is the key to effective management of the issues.

The assessment of risk of violence for Māori begins with an understanding of the individual's cultural context. This provides the clinician with some insights on how best to arrange the assessment to optimise engagement and enable a comprehensive understanding of the individual. This is imperative, as risk of violence is broader than psychiatric and cultural factors and includes issues related to social and intergenerational disadvantage, socio-economic status, history of personal abuse and significant whanau disruption.

Components of Cultural Competence

Cultural competence begins by understanding the concept of cultural diversity. Māori are a diverse population due to the impact of colonisation, assimilation and acculturation, and the evolving process of cultural reclamation and revitalisation. Clinicians should not make assumptions about cultural identity or the relevance and meaning of culture to an individual. This is particularly important when considering the impact of culture in the context of assessment and management of risk of violence.

Cultural competence lies in three spheres relating to the realms of attitude, knowledge and skill.

Attitudinal Competency

Attitudinal competency includes an awareness and objective view of clinician's cultural heritage, assumptions, biases and values, and the impact of these on personal and professional beliefs and behaviours. It includes awareness of the baggage that every clinician brings to therapeutic encounters and how these may contribute to a power differential. When two cultures conflict due to lack of awareness of the nature, reasoning and importance of the cultural constructs of all ethnic groups, the inevitable outcome is bias and loss of equality (Arnold, 1992).

Attitudinal competency should assist mental health workers to approach people of a different culture with respect and a genuine willingness to learn more about and value their world view. This is likely to enhance mental health workers' ability to engage with people of a different culture and to create an environment where people feel comfortable discussing difficult issues. This is a necessary prerequisite for assessing and managing risk of violence. It should allow workers to identify their stereotypes and to reflect on how these may impact on the way they approach, understand or treat consumers from a different culture. It should allow mental health workers to feel confident and comfortable offering Māori people the opportunity to have Māori cultural advisors present during the assessment, and asking for assistance when they are struggling at the interface between their own culture and the culture of others.

Knowledge Competency

Knowledge competency includes understanding the significance and relevance of Te Tiriti O Waitangi and the impact of colonisation on the health status of Māori. This requires an appreciation of the unique position and rights of indigenous people, and acceptance and respect of cultural diversity and difference in a multicultural society. It requires awareness of the holistic approach to health held by Māori and captured by the Whare Tapa Wha model. It recognises that language and communication styles and idioms of distress may differ. It increases awareness of how miscommunication and misunderstanding may lead to diagnostic confusion or error with significant treatment implications. Knowledge competency requires an understanding of different views on the concept of whanau, individualism versus tribalism and tribal bias (kawa, tikanga), and how these may impact on principles of autonomy, self-determination and confidentiality. Further it requires respect of Māori explanatory models of illness (mate Māori, matakite) and of the right to access traditional healing practices for their recovery (karakia, rongoa, mirimiri, tohunga).

Knowledge competency should assist the mental health worker to understand how cultural factors contribute to the uniqueness of each tangata whaiora and their whanau, and how these may contribute to the risk of violence. To enhance recovery and to reduce distress and the potential for violence, it is a requirement to understand and value how tangata whaiora and their whanau make sense of what is happening and what they determine is required. It should assist the mental health worker to better understand the cultural elements of the relationship between tangata whaiora, whanau and themselves, and how these may impact on rapport, engagement, therapeutic alliance and the quality of information that has been exchanged.

Skill Competency

The expectation is not that mental health workers will develop all the skills necessary to manage the cultural interface but, rather, to recognise their

limitations and to know when it may be appropriate to access skilled cultural workers to facilitate the process.

Engagement and Therapeutic Alliance

Good clinical practice and effective risk assessment and management cannot occur when there is no engagement. An ability to engage tangata whaiora facilitates the more complex task of developing a therapeutic alliance, which is not an end unto itself but rather a means to an end (a way of facilitating the recovery process). This is probably the greatest challenge encountered by non-Māori mental health workers and the involvement of skilled cultural staff (including kaumatua and kuia) may provide assistance. Consideration of the setting (marae setting), rituals of encounter (karakia, whakawhanaungatanga), dimension of time (as long as is necessary), the language spoken and even the way questions are framed during the assessment may facilitate engagement and therapeutic alliance.

Tangata whaiora with serious mental illness who have considered violence or acted violently in the context of a relapse may find it difficult to disclose or discuss this information. However they are acutely and painfully aware of the burdens associated with this behaviour, as are often their whanau. In a publication by the Mental Health Commission (2000b), one family member described the impact of his brother's behaviour:

"We couldn't believe it. It was like a nightmare, it wasn't real. We thought they must have got the wrong person because he had always been so non-violent. It was devastating for Joe once he became well again. He's deeply conscious of some of the terrible things he's done. The media pestered Mum. They were on the doorstep all the time. She stopped answering the door after a while and she had to change her phone number. It was very, very stressful for her".

The ability of mental health workers to explore areas of risk in a culturally competent and respectful manner, and to support and assist tangata whaiora and their whanau to prevent episodes of violence or self-harm, can have a profound effect on people's lives and their journey of recovery.

Pacific Islands People in New Zealand

Pacific Islands people comprise one in 16 (or 231,801) people in New Zealand (2001 census). The Pacific Islands population is a young one with half of the Pacific Islands population in New Zealand under 20 years of age. It is also a rapidly growing population and is expected to comprise 12% of the total New Zealand population by 2051. Within it, it is ethnically diverse, being predominantly of four main island groups, namely Samoan, Cook Island, Tongan and Nuiean, but with growing communities from Tokelau, Tuvalu and the Solomon Islands. The majority are New Zealand born and by 2050 it is predicted that 90% of the population will be New Zealand born. Most live in urban areas, primarily in Auckland and Wellington.

Data on the mental health status of Pacific Islands people is still lacking, and largely drawn from institutional data, which is dated (Te Puni Kokiri Ministry of Māori Development, 1996), but major gaps in health, educational and socio-economic status, and over-representation in correctional populations is apparent. Pacific Islands people are over-represented in forensic services (Ministry of Health, 2001b) and prison, where elevated rates of mental illness are to be found (Simpson et al., 1999). The Mental Health Commission (2001) notes that Pacific Islands people experience a high degree of stigma, poor service access with late

presentation, and services that do not understand the complexity of their needs (Mental Health Commission, 2001b). Many people experiencing mental health problems in Pacific Islands communities never access mainstream services.

Impacting on the mental health needs of Pacific Islands people is the complex interplay of factors including socio-economic disadvantage, language, loss of traditional structures of health and well-being (including the weakened position of the church), discrimination, unemployment, and drug and alcohol problems.

Malo (2000) described themes of diversity and commonality of experience of Pacific Islands consumers and identified the need, wherever possible, to have Pacific Islands mental health services established to overcome stigma and communication barriers (Malo, 2000). There are strong links between Pacific Islands people, such as similarities in perception of the spiritual world, yet each Pacific Islands nation has its own customs, traditions, rules of conduct, beliefs, values, language and protocols. However, each individual Pacific Islands person needs to be acknowledged as unique. Pacific Islands people are not Māori, and thus do not expect to be treated according to others' values and traditions. Pacific Islands consumers have given a strong message that wherever possible they wish to have access to Pacific Islands-run services, which enhances their ability to recover as these services are able to bring Pacific Islands understandings and belief systems into service delivery (Malo, 2000). Services created to specifically target Pacific Islands people and run by Pacific Islands personnel appeared to be of the most benefit, although mainstream services that employed Pacific Islands staff were also beneficial.

This emergent population with complex needs requires a specific response that is based on the concepts of health and well-being drawn from Pacific Islands cultural origins. The mental health of Pacific Islands people is intrinsically bound to their holistic view of health, which incorporates beliefs and values relating to family, culture and spirituality. One relevant model of health, the Fonofale model (first created by Fuimoana Karl Pulotu-Endemann), attempts to integrate common themes of health and well-being shared by many Pacific Islands people. Using the metaphor of the house, the roof embraces cultural values and beliefs that shelter life, and the foundation is the family. The roof is held up by four pou or posts, being spiritual, physical, mental and other dimensions, with the fale encapsulated by dimensions of time, environment and context. Recovery from a Pacific Islands perspective should integrate the spiritual, physical, emotional and family well-being components.

As for Māori, the assessment of risk of violence begins with an understanding of the person's cultural context. This model provides the clinician with the range of factors that need to be considered and awareness of the need to involve people with the necessary expertise to address the complexities of the health and illness experience for Pacific Islands people. Risk of violence is broader than psychiatric and cultural factors, and must embrace an understanding of migration, language and the traditional health structures of the family.

A principle value for Pacific Islands mental health services is establishing clarity at the first point of entry into mental health services, which represents the most appropriate and effective phase and context to accurately assess the person's perceptions from a cultural perspective. Establishing and providing clarity at the assessment phase for Pacific Islands people is important so that misunderstandings due to diversity in language and diverse cultural values and beliefs are minimised. This may involve obtaining information through interpretation or translation of

language from the consumer, the family and from significant others. Information can be shared with all concerned.

For Pacific Islands people, a process of engagement that actively includes family is crucial. Consumers and family need both general and specific understanding about aspects of care necessary for treatment and recovery from mental illness. Language may be a significant hurdle in communication as may the style of service provision.

Components of Cultural Competence

In addition to the attitudinal, knowledge and skill attributes noted above for Māori, cultural competence for Pacific Islands people must not only include an appreciation of the diversity of Pacific Islands experience, but should also acknowledge the common themes of Pacific Islands cultures, especially the role of family, authority and church in Pacific Islands life (Mental Health Commission, 2001b). This should include an awareness of relevant Pacific Islands models of well-being such as the Fonofale model. The clinician should explore the person's particular cultural identity, and be able to work alongside Pacific Islands mental health workers, family, relevant community persons and the consumer in the process of recovery.

Overview

The unique New Zealand cultural context provides a challenging environment for clinicians to establish the risk assessment and management components of good care plans. Attention must be paid to cultural factors throughout the process, from initial engagement, through establishing a therapeutic relationship, to developing a shared understanding of the consumer's pathway to violence and consequent pathways to safety and recovery. Additional cultural expertise is likely to be beneficial during this process and in some cases will be pivotal in developing an accurate understanding of the situation. This applies both to the development of a general care plan (which may be protective against violent behaviour in itself) and to specific beliefs and perceptions arising from violent behaviour, which are central to core risk assessment processes.

Relevant Legislation

Clinicians must practice within the law, and in keeping with good clinical practice from a technical and ethical perspective. Legislation attempts to codify powers and responsibilities of clinicians in relation to people with serious mental health problems whose mental disorder gives rise to risk to themselves or others. Legislation also codifies the rights and protections for people subject to its powers. These powers and responsibilities are fundamental for the well-being of the person concerned, but adherence to these powers and duties may well reduce risk to other members of society also. Clinicians need to be aware of these dual, generally compatible, but at times competing duties.

Although parliament drafts and passes acts or statutes, the interpretation of the wording of acts and the intent of provisions within the act are further defined in case law, which may alter assumptions about what wording in legislation means. This is one of the reasons why introducing new legislation is often associated with uncertainty, until the meaning of the act and its procedures become understood and ingrained in everyday practice. As a consequence, processes and interpretations may evolve through time.

In this brief overview, attention is drawn to three key pieces of legislation.

The Privacy Act 1993

This act defines the structure for the gathering, storage and use of personal information. The Health Information Privacy Code 1993 defines these rules specifically in relation to health information. Rule 11 defines the circumstances in which health information can be released, including the routine sharing of health information with others involved in the person's care. This is the most common sharing of health information. There is no hard and fast rule for these situations, but two principles apply.

- First, the information is personal information and thus it should always be dealt with sensitively in relation to the person's desires about who should receive information, and how much information is to be shared. This is part of the collaborative process of recovery planning that should be undertaken with each patient.
- Second, sharing of relevant information in a supportive way with others genuinely concerned for the person's well-being is crucial for care delivery. If those that the person is living with are family, they will have much information relevant to understanding the nature of the person's problems and support needs. They are partners in the care of the person, know the person better than anyone else and are a huge asset in their treatment and recovery.

If the person is living or flatting with others who are not relatives, information should be shared depending on the person's wish, how involved in the person's care the other persons are, and if there are any specific risk issues that may emerge in relationship to them. The patient should always be informed of, and involved in, the process of telling others as a part of the collaborative process of care planning.

There are particular circumstances that arise when a person presents a serious risk to others. In ethical codes, clinicians are defined as having a duty to protect third parties who may be at risk from a person in contact with mental health services. That duty, at times erroneously referred to as a duty to warn, requires the clinician to take all reasonable steps to protect any potential victim. This may involve steps such as admitting a person to hospital, increasing support, invoking the Mental Health (Compulsory Assessment and Treatment) Act 1992, or changing medication. If these or other interventions cannot adequately reduce or control the risk, it may be necessary to inform others, without the person's consent, in order to reduce the risk. Rule 11 (2) (d) authorises the release of health information *if the release of that information is necessary to prevent or lessen a serious or imminent risk to others*. This may involve informing external agencies such as the police, or informing a specific potential victim of a specific risk. If this is necessary, the patient should be told, at an appropriate time, that you have done so or will do so.

Clinicians should note that individual professions have their own ethical rules, which define obligations in relation to confidentiality and the sharing of information, and which are not necessarily fully covered under the code. In other words, behaving according to the requirements of the code may not meet all ethical obligations. The Privacy Commissioner and the Mental Health Commission (2000) have produced a very valuable guide to the application of the code in mental health services.

Mental Health (Compulsory Assessment and Treatment) Act 1992 (and Amendment Act 1999)

This act provides the legal structure for when someone with mental disorder (as defined in sections 2 and 4) can be made subject to compulsory assessment or treatment. The reasons for such intervention may be because of a serious risk to the person's own health or safety, or because they present a serious risk to others. The act's powers may only be invoked if the person is either unwilling or unable to consent to such treatment, and where invoking compulsory treatment is necessary to reduce risk. The act defines obligations to consult family and ensure that assessment and care is culturally appropriate.

As indicated in the section addressing lessons gained from inquiries, the act is a very important risk management tool. Its structure allows for preventive intervention, so that a person who due to mental disorder poses a serious risk to the health or safety of self or others may receive treatment to reduce that risk.

Compulsory care may also be used to ensure ongoing compliance with treatment and engagement with support in the community following discharge from hospital, as well as readmission should risk escalate.

The Guidelines to the Mental Health Act (2000) describe these applications in greater detail. Throughout the use of compulsory care, there must be a very careful process of explaining to the person and their family the reasons for it, and efforts must be made to ensure they are as involved as possible in the decisions regarding care throughout the process.

Newer techniques, such as advance directives that can guide intervention should someone suffer a relapse of illness, may decrease the need for compulsory intervention. An advance directive is a statement made by the person of how they wish to be treated should they become unwell and become less able to perceive or express their needs. Whilst not legally binding, respect for the person's expressed wishes may allow for more therapeutic and acceptable intervention.

Victim Rights Act 2002

This act defines the rights of certain victims of violent behaviour by people with mental illness to be informed of changes in aspects of a patient's care. It only applies if a person has been convicted, been found unfit to stand trial or found not guilty by reason of insanity of criminal behaviour. Victims must register with the police. If accepted as a victim in terms of the act (this may include family members of victims under certain circumstances), mental health services are obliged to inform the victims of certain changes in the person's care and progress. A coordinator is employed in each forensic service to ensure this obligation is carried out for patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Other Issues

Whilst these acts codify aspects of behaviour that are expected of clinicians, also relevant are common law duties and ethical duties. Perhaps one of the most difficult of these duties is the issue of initiating a criminal complaint against a patient. Charging an inpatient who may have committed an act that may be liable to criminal sanction is currently a controversial issue. There is a conflicting range of duties for those responsible for the person's care to consider:

- duty to the patient, who may be acutely unwell and retains a right to proper treatment even if they have been violent (behaviour which may well be the product of their illness);
- duty to the victim who has a right to lay a complaint with the police if they believe they have been the victim of a criminal act;
- a duty to the staff of the mental health facility in which the event has occurred, who have a right to a workplace of acceptable safety.

These issues need to be weighed with care at a senior level within the service, possibly in liaison with forensic services.

Laying a complaint with the police should be seen as a serious incident and documented appropriately. It is important to recognise that it is a decision of the police to lay criminal charges, not of the complainant or the clinical service. Should legal proceedings commence, bail conditions need to facilitate the meeting of clinical needs whilst the criminal and clinical processes continue. More serious charges may necessitate remand in prison or to a forensic facility. Effective clinical handover should occur in both cases. A court ordered psychiatric report may be of value to define risk responsibilities and treatment issues.

Competencies and Risk Assessment

The process of risk assessment is a multidisciplinary process. The undertaking of the requirements by multidisciplinary team members depends upon the scope of practice of the health professional's discipline and the worker's practice experience and knowledge. The purpose of this section is to define who should be responsible for which requirements during risk assessment.

The Health Practitioners Competency Assurance Act 2003 requires that the regulatory bodies of all health professions describe the profession's scopes of practice, so that there is a clear understanding of what each profession does. Furthermore, the regulatory body is required to determine the competency or *"the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance"* (Nursing Council of New Zealand, 2004). These are the precursors for the establishment of quality audit processes that maintain professional standards.

For some professions, such frameworks have been part of their history. The medical profession has an existing framework under the Medical Practitioners Act 1995. Scopes of practice occur in three registers, which acknowledge the transition from education to practice of beginning clinicians, the need for oversight of proficient clinicians and the role of expert clinicians (Medical Council of New Zealand, 2004; St George, 2001). For nurses, psychologists, occupational therapists and social workers, consultation processes are presently occurring with stakeholders toward the development of frameworks in response to the new legislation.

The following broad recommendations are made to guide the competencies of various health professionals in risk assessment. All health professionals undertake a period of probation during their transition from education to practice. All beginning clinicians should be expected to have a knowledge of risk factors, which is incorporated into clinical assessment. They should also be responsible for assisting in the monitoring of risk. These requirements should occur with the

support provided by multidisciplinary team decision-making processes, and the supervision or oversight provided by their discipline (see Table 1, column two).

The requirements of risk formulation, and the development and ongoing review of the risk assessment plan, are advanced competencies and should be undertaken by proficient health professionals, other than beginning clinicians. These requirements should occur with the support provided by multidisciplinary team decision-making processes, and the supervision or oversight provided by their discipline (see Table 1, column three).

Table 1. A Map of Competencies

1. Requirements	2. Beginning clinicians	3. Proficient clinicians	4. Expert clinicians
Determination of risk factors	✓	✓	✓
Clinical assessment	✓	✓	✓
Use of actuarial tools	x	x	✓
Risk formulation	x	✓	✓
Risk plan development and review	x	✓	✓
Risk plan monitoring	✓	✓	✓

The application of actuarial tools to the process of risk assessment requires advanced knowledge and in some cases is restricted to certain health professional disciplines. The use of these tools should be confined to expert clinicians within the disciplines concerned who have undertaken the required training (see Table 1, column four).

In some contexts, the multidisciplinary team consists of valued members who are not health professionals. Mental health support workers have an important role in the ongoing care with mental health consumers. However, their educational preparation, knowledge and skill base are variable (Ministry of Health, 2001a). Their role in risk assessment should be confined to the monitoring of risk under the direction of the multidisciplinary team. Furthermore, enrolled nurses practise under the direction of registered nurses caring with consumers who have predictable health outcomes (Nursing Council of New Zealand, 2004). Similarly, their role in risk assessment should be confined to risk plan monitoring under the direction of registered nurses.

Part 3: Best Practice Guidelines

Best Practice Guidelines for Risk Management

We have been explicit in our view that risk assessment and management comprises one part of the overall care plan, and that much of the risk of violence by mental health consumers can be diminished by the provision of adequate mental health care. The purpose of this section is to outline best practice guidelines for consumers suffering from serious mental illness, particularly those involving psychosis; aspects of risk assessment and management more specifically related to violent behaviour are addressed in the following section.

A critical component of risk management is to ensure that mental health consumers can be supported in their recovery. The consequences for consumers and their family when they are either unable to access services or receive inappropriate help from services can be devastating. An important publication from the Mental Health Commission describes the experiences of consumers who have been treated within an inpatient forensic service because of violence towards others caused by their untreated mental illness (Mental Health Commission, 2000b). Both they and their families outline the serious impact of their violence and their subsequent mental health inpatient treatment on their lives. In the words of one consumer:

“But at the end of the day I couldn’t access help. If the general mental health system had been functional and accessible I would never have been charged and sent to the forensic services in the first place.” (Mental Health Commission, 2000b)

Consideration of outcomes for consumers is the primary motivation for the following guidelines, which represent good clinical practice. The key to effective risk management extends from comprehensive clinical care. The five broad headings relate to key areas that must be considered. Each of the five sections must be evaluated on an ongoing basis. They are to be considered concurrently not sequentially.

In practice, one of the most common areas where risk management is imperative is with people who have a psychotic illness that may be complicated by substance misuse. Their risk can be modified if they have access to appropriate and effective mental health services. Mental health services in New Zealand have been shown to have a high percentage of people with the diagnosis of schizophrenia. In the New Zealand Mental Health Classification and Outcomes study, which had a sample of over 12,500 consumers from eight different district health boards, 36% had a diagnosis of schizophrenia, which was the most common diagnosis (Gaines, Bower, & Buckingham, 2003). Some of the following discussion has greater applicability for this population.

Models of Service Delivery

The main purpose of considering the type of service delivery is to optimise access, early intervention and optimal care. Some services have been criticised by both consumers and family members as being rigid in their structure and not allowing for different responses according to the presenting issue for the consumer. For example, in a Mental Health Commission review of crisis mental health services (Mental Health Commission, 2001a), one consumer states:

“All this delay increases the risk, there is a decline in your sickness and things get worse with your family/whanau or where you are living and there is more risk of harm.”

Different models of service delivery are indicated for people presenting to mental health services in relation to their level of acuity, symptom severity and disability, and willingness to engage. During the process of clinical service delivery decisions need to be made regarding which service is the most appropriate. There are four broad types (not including culturally specific services) that are described in the literature for adult mental health consumers.

Assertive Community Treatment

Assertive community treatment (ACT) has a clear evidence base demonstrating its effectiveness in reducing the frequency and duration of hospitalisation for people with serious mental illness, particularly if such people have had long periods of hospitalisation, criminal justice involvement, housing instability and service disengagement (Burns, 1995). It is also effective in increasing quality of life and treatment engagement, and reducing the risk of violence associated with mental disorder. A key component of ACT is the mobile delivery of services to settings in the community rather than office-based care. Staff members have low caseloads, allowing high-frequency face-to-face contacts. ACT services offer both crisis resolution and individualised continuous care based on consumer need. Strategies to increase adherence to medication are a key feature of ACT.

Clinical Case Management

Clinical case management is a model of service delivery that is designed to assist people with serious mental illness in a broad range of dimensions including housing, psychiatric treatment, general health care, family and social networks, and benefit entitlements. An identified case manager works with a psychiatrist and the consumer to develop a comprehensive care plan. Often this involves collaboration with non-governmental organisations. Service contacts tend to be a combination of clinic-based care and home visits, and the frequency of contact and the ability for crisis resolution is less than that of ACT. This model is appropriate for people who have ongoing disability and require assistance with recovery. Given the association of risk for violence with lack of housing and other social supports, the importance of case management in the context of risk management is self-evident.

Clinic-Based Services

Clinic-based services are appropriate for people who have lower levels of acuity, are able to reliably attend appointments either independently or with the assistance of support people, who have lower levels of disability and do not require rehabilitation. For people who can actively engage in managing their violence risk, clinic-based services play an important part in monitoring and maintaining stability.

Crisis Services

Crisis services are designed for people who because of the severity of their symptoms or presenting risk behaviour require rapid and mobile assessment and treatment. Most effective models have a capacity for crisis resolution in the community in addition to access to acute inpatient units.

In practical terms there are many different ways services can orientate their structure to ensure that consumers and their families have a range of available service delivery models. In some district health boards, consumers can be offered either of these models from within one community mental health centre. In other district health boards, parts of these service components are provided by stand-alone teams.

Engaging with Consumers and Families

A fundamental aspect of risk management is the ability of clinical staff to effectively engage with the consumer and their family or carers.

Therapeutic Alliance

The therapeutic alliance is an ongoing working relationship between the clinician and the consumer that allows for the identification of risk factors and clinical needs as well as for agreements regarding goals and risk management strategies. Literature on recovery describes the need for therapeutic relationships that are respectful and promote hope. Knowing the person beyond the manifestations of their illness and valuing their cultural values and personal strengths enhances the relationship (Deegan, 1996). A strong therapeutic alliance provides a safe environment for the consumer to discuss symptoms of mental illness, life circumstances and safety concerns. Thus, the therapeutic alliance creates opportunities for a more comprehensive understanding of the consumer's mental state and risks and may therefore enhance motivation to engage with proposed treatment and risk management interventions.

In the formation of a therapeutic alliance, sensitivity to a consumer's sexuality, religious and cultural background is vital. Clinicians also need to strive for effective, ongoing relationships with families and carers. Families and significant others are often the first people to identify signs of relapse and are often the targets of violence. They may be instrumental in helping the consumer access services.

Competency four of the New Zealand Mental Health Recovery Competencies describes "A competent mental health worker has the self-awareness and skills to communicate respectfully and develop good relationships with consumers" (O'Hagan, 2001). It details the need for effective communication skills where the staff member listens, takes the experiences of the consumer seriously and works with respect. It also encourages a communication style that shares information in an appropriate manner and that is not technical.

This is not to imply that being caring alone is a sufficient expectation. In *Recovered, Not Cured. A Journey Through Schizophrenia*, Richard McLean highlights the importance of an effective and informed therapeutic alliance in his efforts to seek help for his psychotic symptoms (McLean, 2003). The first doctor he consulted appeared to have good relationship skills but because this was not integrated with an appropriate knowledge base there was an unacceptable delay in accessing appropriate assistance. In describing the interaction he states:

"He was friendly but I got the impression he was leading me away from the story that I wanted to tell him. I took this as confirmation that the conspiracy had liaised with the doctor, that he thought I deserved to be punished... The fact that he hadn't questioned theories that even I thought were ridiculous proved it. I didn't know then that a lot of doctors were not that well versed in psychiatry... This

doctor saw a person who was a little odd maybe, but generally well mannered, and he sent me on my way. I felt confused."

By contrast he describes an interaction with another doctor who helped him access effective treatment:

"He knew...deep down I thought he was the enemy. He asked me how I felt in my younger teenage years and said I could achieve this happiness again...His professionalism was impeccable and without that meeting I do not know where I would be now. He gave a solid argument that the medication would help but said that it was my choice whether to take it or not. He explained the pros and cons and left the ball in my court...."

Working with Families

There is a national recognition of the importance of services working with families both in the National Mental Health Standards (Ministry of Health, 1997b), the New Zealand Mental Health Recovery Competencies (O'Hagan, 2001), the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Ministry of Health Involving Families Guidance Notes (Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists, 2000). Clinicians need to strive for effective, ongoing relationships with families and carers. Families are often the first people to identify signs of relapse and risk of violence to self or others. They can be instrumental in helping the consumer access services. Inquiries into tragic outcomes have highlighted the importance of respectful listening and open communication between mental health providers and families. When the consumer has not been able to access or receive effective help and violence occurs as a consequence of untreated illness, family members are more likely to be victims than strangers.

"Families have to know what is going on. It's not that we want to pry or cause trouble. We are the front line, we are the ones living with the person, we are the people who make sure they take their medication and that they don't kill themselves. And we support them as they recover. We have to know what to do, we are the people who actually care the most." (Mental Health Commission, 2000a)

"It's a safety net for him. If Joe gets another attack he may be able to do something about it himself. We're now more confident that we could put pressure on various agencies and they would do something about it." (Mental Health Commission, 2000b)

Compulsory Treatment

Sometimes the best care requires the use of compulsory treatment because of the severity of risk or the lack of other effective or safe options. A combination of mandatory community treatment and regular clinical care has been shown to reduce the rate of violent behaviour in people with serious mental disorder (Swanson, Swartz, & Borum, 2000). The use of compulsory treatment does not reduce the need to strive for an effective therapeutic relationship. The goal of the therapeutic interventions remains to restore control to the individual so that she or he can manage her risk safely and responsibly.

There is clearly a tension between principles of autonomy and self-determination and the use of compulsory treatment. If clinicians are working with a consumer who is under the Mental Health (Compulsory Assessment and Treatment) Act

1992, it is essential that the ethical and therapeutic issues involved are carefully considered. Although much has been written of the abuse of consumer rights by use of compulsory treatment, there has also been well-documented serious violence when clinical services failed to use compulsory treatment when it was clearly indicated. Gunn cites an example in the Christopher Clunis case where several mental health services deemed the use of compulsory treatment as an inappropriate way of providing services to a man with complex and high-risk mental health needs (Gunn, 1996; North East Thames and South East Thames Regional Health Authorities, 1994).

Discussing Risk and Recovery

A core part of risk assessment and management is discussing risk issues openly with the consumer. A lack of attention to symptoms, coping styles or situational factors that increase risk can seriously impede recovery and risk management. In this document the focus is on risk to others. However, there are many broad dimensions of risk including risk to self, sexual risk, financial risk, risk of exploitation and risk of homelessness. The motivation for therapeutic engagement and self-monitoring can also be enhanced by an open discussion of risk issues.

Antipsychotic Medication

Untreated delusions and hallucinations are important factors in violence by people with psychotic illness. The effective use of antipsychotic medication is, therefore, a fundamental aspect of risk management for these people. Atypical antipsychotics have a lower propensity for extrapyramidal side effects and there is some evidence that they lead to a lower risk of relapse and hospitalisation than typical antipsychotic medication (Csernansky, Mahmoud, & Brenner, 2002). For those suffering from treatment resistant schizophrenia, there is evidence that clozapine can be associated with lowered rates of suicide attempts, violence and substance abuse (Citrome, Volvka, & Czobor, 2001; Green, Burgess, & Dawson, 2003; Kane, Marder, & Schooler, 2001; Meltzer, Alphas, & Green, 2003).

Psychological Strategies

As stated above, the risk for violence can result from a number of factors that may or may not be related to the symptoms of a psychotic illness. Research since the 1980s by Mednick and his group has suggested a schizophrenia spectrum, which indicates a continuum between certain types of personality disorder and schizophrenia (Brennan, Mednick, & Hodgins, 2000). More recent research supports this notion by linking early maladjustment and aggression with emergence of schizophrenia in later years (Nestor, 2002). However, regardless of this connection, risk research has shown that the presence of certain personality disorders, especially borderline-narcissistic and antisocial personality disorders, are risk factors for violence. It is likely that the problems with anger and impulsivity, as well as with tolerance and regulation of negative affective states that characterise these disorders, are causally related to violence risk. Furthermore, risk factors such as cognitive distortions and self-righteous attitudes that condone and justify violence, are often present in persons with these disorders. Alcohol and substance abuse, which are per se risk factors for violence, are also prevalent in persons afflicted with the personality disorders mentioned.

Given the high degree of co-morbidity in consumers who come to the attention of mental services of major mental illness and personality disorders with histories of and risks for violence, risk management cannot be limited to treating the symptoms of psychosis. A number of other psychological interventions and mechanisms that help the consumer and the team may be necessary to target

violent behaviour directly, or to support and enhance the risk reduction achieved through psychopharmacological interventions. It is important that such treatment is integrated with the overall care and risk management plan. Obtaining privileges may be made contingent on meaningful and consistent participation in identified treatment programmes, and feedback regarding participation and progress needs to be given to the team on a regular basis. Given the difficulties in establishing and maintaining a therapeutic alliance with these challenging consumers attention to team dynamics and to the interactions of team members with others involved in the consumer's care are especially important. Splitting can lead to a break-down of communication and collaboration between all involved, increasing the risk of violence.

Personal Strength and Resources

A key aspect of risk management is understanding how the consumer can use their own personal resources to effectively manage their mental health. Recovery competency 2 states that a competent mental health worker recognises and supports the personal resourcefulness of people with mental illness. This highlights the importance of the concepts of resilience, wellness and crisis planning in delivering mental health care (Mental Health Commission, 2001c; O'Hagan, 2001).

Working with the consumer to develop a wellness and recovery plan requires attention to the following areas:

- what keeps the consumer well?
- patterns of wellness over time;
- personal triggers or buttons;
- early warning signs and action plans;
- ways of coping and self-management;
- support systems;
- crisis planning and advance directives;
- ways of building wellness.

Leete describes over 20 individual strategies that she uses including such things as checking out reality with trusted others, assertively requesting unambiguous communication, organising the environment to reduce distracting stimuli and recognising early warning signs (Leete, 1989).

Psychoeducation

Psychoeducation is an ongoing process of working with the consumer and their families, and involves sharing information about their conditions, risks, available treatment options, and relapse planning. It has been shown that interventions that combine education and support with skills training for the consumer and his or her support system further reduces the rate of relapse and contributes to improved family functioning and well-being (Dixon, Adams, & Lucksted, 2000).

In this context it is important that skills training directly addresses risk behaviours, as well as associated symptoms of mental disorder. The areas that are particularly

relevant in this context are distraction, distress tolerance and emotion regulation skills, interpersonal competence and communication skills, as well as problem solving, anger management and violence prevention skills.

Adherence Therapy

Adherence therapy is an intervention designed to help people with psychotic illness take medication. It uses strategies from both motivational interviewing and cognitive behavioural therapy to explore individual understanding of the role of medication and barriers to adherence (Kemp, Kirov, & Everitt, 1998). Adherence can be enhanced by ensuring simplicity of prescribing regimens and attention to practical issues, including side effects and where the medication can be obtained. In the context of risk management the scope can be expanded to include discussions of risk issues, including adverse consequences. Motivation can be enhanced further via joint development and contracting regarding specific treatment and risk management plans.

Strategies for Dual Diagnosis Substance Misuse

Substance misuse increases the risk for harm to self or others. The extent to which this happens is to some degree dependent on the specific substance, the quantities taken and the characteristics of the consumer. Motivational interviewing and relapse prevention strategies are commonly employed and may suffice to achieve harm minimisation. However, for some consumers the risk associated with substance use is so high that strategies to support abstinence are indicated.

Integrated services that have the same group of clinicians working in one setting to address both mental health and substance misuse have been recommended in the literature as the most effective model for people suffering from schizophrenia (Drake, Essock, & Shaner, 2001; Todd, Sellman, & Robertson, 2002). In lieu of dual diagnosis services, a high level of integration can be achieved via joint meetings and regular contacts between the providers of mental health and drug and alcohol services. It is particularly important that the models of intervention are understood and integrated, if possible. For example, a relapse prevention framework can be used for mental health, substance use and violence issues. Similarly, certain skills (e.g. distraction, distress tolerance and emotion regulation skills) are useful in managing both symptoms of mental disorders and substance use precursors.

Psychotherapeutic Interventions

Under certain conditions, risk management can only be successful on a long-term basis with the help of psychotherapeutic approaches. This may be the case when persistent cognitive or emotional schemata or disturbances drive the violent behaviour (Meloy, 1997) or interfere with the consumer's ability to profit from treatment. For example, people with borderline personality disorder or post-traumatic stress disorder may not be able to abstain from substance use until their ability to deal with flashbacks and emotional flooding has sufficiently increased. A combination of psychopharmacological and psychotherapeutic interventions might be necessary under such circumstances. Cognitive behavioural approaches, as well as dialectical behaviour therapy, have been found to be effective in such scenarios. There is also some evidence that a combination of cognitive behavioural and relapse prevention approaches can reduce risk for violent offending in persons with severe antisocial personality disorder (Wong, 2001).

Rehabilitation

Housing

Stable housing is a fundamental component of risk management. Homeless mentally ill people have a higher arrest rate for both violent and non-violent crimes and are more likely to be victims of crime than people with mental illness who have secure housing. Outcomes for homeless people with mental illness are so poor that clinical services must prioritise helping the consumer obtain stable housing (Hooper, Jost, & Hay, 1997).

Interagency Collaboration

Consumers may have other agencies involved in providing mental health treatment and support. Developing a risk management plan with the consumer and family should involve key people, including mental health non-governmental organisations and general practitioners. It is necessary for the consumer to have a confiding relationship with health professionals and interagency collaboration does not mean that all information is disclosed. The consumer should be nominating key people to involve in information sharing and should be an active participant in this process. The situations where information should be disclosed even if the consumer disagrees have been outlined earlier in the description of the Privacy Act 1993.

Community Utilisation

A key component to mental health treatment is supporting the consumer to regain or develop skills and confidence. Comprehensive risk management appreciates the importance of assisting people with vocational and social goals. Different types of interventions will be appropriate according to the individual's needs and goals. Working with consumers in these areas can improve service engagement and therapeutic alliance. For the individual, there are gains in self-esteem, which can reduce substance misuse and improve motivation to manage their mental health effectively.

Consumer literature has identified active participation in life to be a key component in recovery. Leete describes how work motivates her, provides positive structure for her life, gives her new skills and something to look forward to, and increases her sense of being accepted and part of the community (Leete, 1989).

Part 4: Practical Issues

Issues of Resistance

Through informal discussions, the working group identified negative attitudes towards the risk assessment process held by many mental health workers and colleagues. In some cases, the degree of resistance was of significant intensity. Further, the nature of the issues underpinning these resistant feelings were not uniform; a range of perceived problems with the risk assessment process were articulated.

Though anecdotal, we felt this was valuable information to try to capture, as there is significant potential for human factors to undermine the risk assessment process, irrespective of the quality of the available tools. Recognition of some of these factors is the first step in addressing the various issues. Therefore, we attempt in this section to simply describe the nature of some of the resistance expressed towards risk assessment.

- **Not enough time** – Some front line workers considered themselves to be too busy to spend time filling out forms.
- **Too long** – Related to the first point, a strong resistance was around completing forms that were perceived to be far too long. We observed criticism of forms for being too long even when, in fact, they were at the lower end of the range we observed.
- **Too much detail and becoming overwhelmed** – There was a strong feeling that carrying out a competent and adequate risk assessment necessarily involved the collation of large amounts of information, which inevitably led to a state of being overwhelmed.
- **Not core work** – Some mental health workers perceived risk assessment to be a task that was *additional* to core clinical work, rather than integral to it. For some, the completion of risk assessment forms represented an exercise in bureaucratic defensiveness, rather than something that added clinical value.
- **A forensic task** – A common perception was that risk assessment and management was a task for forensic services and that forensic practitioners have much more time available to carry out risk assessment duties. An associated belief was that most general adult mental health consumers did not require risk assessment; it was only those that posed the higher levels of risk that needed to be subjected to this process.
- **Scapegoating** – Significant concern was expressed about how the risk assessment process could lead to unfavourable outcomes for clinicians. On one hand, some clinicians thought that the quality of their risk assessment process might be deemed inadequate or criticised in some way in the event that one of the consumers under their care acted violently. Alternatively, others felt that the avoidance of written risk assessments was advantageous because it avoided possible legal action based on failing to carry out identified risk management plans.
- **Poor quality** – Some practitioners felt that the risk assessment proformata that were available to them were of dubious quality. Although they could

see merits in the risk assessment process, they struggled with what they understood to be forms of unacceptable design and content.

- **Lack of resources** – Some expressed an unwillingness to identify the consumer's clinical and risk management needs if it was known that the service would not have the resources required to fulfil these needs. It was felt that it would be potentially exposing to the clinical team and possibly self-defeating to identify interventions that were thought relevant but were not available.
- **Increased risk** – Some people expressed the view that talking about violent behaviour was likely to give the consumers ideas, such that their risk of violence might be *increased* or precipitated by such a process. This is reminiscent of the well-documented reluctance that some junior workers have when interviewing people about suicidal thoughts, because of the fear that this will actually increase risk.
- **Unskilled** – Some workers felt that they lacked the necessary training and competencies to carry out an adequate risk assessment. They were willing to contribute to risk assessments and had a general sense of the type of information that was relevant but did not feel confident in their ability to weigh things up correctly.

Perhaps the most worrying of the various resistances centred on the belief that risk assessment and management were *not* part of the basic clinical responsibilities of workers in the mental health field. This was typically associated with an absence of the conceptual understanding that safety was an important clinical need for the consumer of mental health services, and those around him or her (and, indeed, a foundation for the provision of adequate mental health care and recovery).

The process of discussing the risk assessment process with colleagues across professional domains also highlighted the extremely wide variation in the quality of existing practice. Some services were clearly well-organised in terms of their risk assessment policies, procedures and proformata. Interestingly, the quality of the paperwork did not necessarily reflect the degree of engagement of practitioners with the process. For example, one service with an impressively well-organised approach to risk assessment and management based on a series of carefully constructed forms reported relatively low levels of adequate or competent completion of the forms. Clearly, the nature of the service and resources are critical to successful risk assessment and management, but good forms alone are not enough.

In summary, resistance appeared to be based on one of two main premises. First, there were clinicians with *no* absolute resistance to risk assessment as a potentially helpful process *per se*; it was just that the individual felt negatively about the process because of the context within which they were expected to function. For example, this opposition could arise from poor infrastructure, high workload, lack of training, lack of support, poor quality of proformata, and so on. Alternatively, some clinicians did *not* accept that risk assessment and management were central or necessary undertakings for people in their profession. Both of these general groups provide insight into the obstacles to be overcome if uniformly competent risk assessment practice is to be achieved. Much will depend on the structural and functional aspects of the services into which the toolkit will be introduced.

Conceptual Framework for the Toolkit

“At its simplest, risk assessment involves two stages: the context in which risk increases, and the signs and symptoms which indicate that risk. For its part, risk management relates to the interventions which contain or reduce risk”

(Berkshire Health Authority: 2002)

As we said in our introductory remarks, risk assessment and management are therapeutic endeavours. The toolkit is designed to provide a simple and clear framework so that issues of violence can be discussed with the consumer. The purpose of this final section is to outline the framework of the toolkit.

We aimed at several outcomes in designing the toolkit. First, it must be relevant to a clinician interviewing a consumer, as well as conducting non-consumer-contact risk assessment activities, for example, reading background files or clarifying background with family members.

Second, the overall framework should be simple so that it is easily learned and remembered. However, specialist general adult or forensic services should still be able to use the same framework, albeit with more depth. This recognises that risk assessment and management are central tasks for *all* mental health professionals and reduces the risk that forensic services are perceived as carrying out a different risk assessment activity. It should help to create a common language for general adult and forensic mental health services.

Third, each level of the framework should have prompts and tools to guide the practitioner. General frameworks are vulnerable to the criticism that they lack enough practical guidance. For example, the clinician may be advised to look for delusions during a mental state examination, but not about the specific aspects of the delusion that should be assessed. This level of specificity is necessary for the documents to have practical value for risk management. A further example might be a risk assessment framework that leaves space for the clinician to formulate the risk, but gives no specific guidance as to what formulation actually means. This can lead to inconsistency and lack of quality in practice. The toolkit gives both a general framework and practical guidance at each stage of the process.

This approach allows for flexibility as clinicians vary in their experience and expertise. The purpose of a toolkit is not to constrain those that are competent or expert but to provide a common language for the process in general terms.

The framework is based on a three stage, sequential and iterative model. The three stages are based upon:

1. accurate information (specifics);
2. pathways to violence (pattern recognition);
3. pathways to safety (recovery).

Reviewing the impact of specific strategies towards establishing safety and updating the risk assessment are important aspects in the process.

Accurate Information (Specifics)

Risk assessment must be an ongoing process that informs interviewing situations, as well as team meetings and case conferences, and that involves the consumer.

At the first stage, it is important that collected information regarding violence is both (1) historical and (2) current, in nature, to provide a foundation for linking the two. This forms a basis for making contextual judgements about the person's current situation and mental state.

An essential part of gathering historical information about violent or threatening behaviour is not to lose contextual information, referring to the interaction between the person's mental state and their social situation at the time. It can be extremely useful to have a simple chronology of violent incidents because this encourages the clinician and consumer to take a longitudinal perspective in thinking about behaviours that put the consumer and others at risk (Gunn, 1996). However, a simple historical chronology also has the limitation that important information about situational aspects of the risk behaviours can be lost. Retaining contextual information of this kind increases the possibility of comprehensively identifying risk triggers and useful strategies for the consumer and clinician to avoid similar situations in the future. Such an interactive conceptualisation of risk also minimises the chances of generic labels being attached to the consumer, which can imply that they pose constant danger rather than situational risk.

Therefore, in the historical information gathering phase, information about the *circumstances* of the incident (e.g. stressful family situation; recent loss or threat; use of alcohol or substances; use or non-use of prescribed medication; aspects that protected against violence; attempts by the consumer or family to establish mental health input) and the *indicators* of the risk behaviour (e.g. the thoughts and feelings of the consumer; whether or not these features were observable to others and over what period of time) should accompany accurate descriptions of what actually happened. The toolkit that accompanies these guidelines reflects the importance of contextual information.

In addition to historical information, risk assessment requires ongoing monitoring of the consumer's *current* thoughts and feelings, a task traditionally seen as falling under the banner of mental state examination. Although mental state examination is a standard clinical task for all mental health professionals, the toolkit resources highlight specific aspects of mental state features and approaches to interviewing that are of particular relevance for the task of risk assessment and management. For example, standard risk assessment models advise clinicians to examine for delusions or even certain kinds of delusions such as persecutory delusions. This is relatively non-directive; we recommend that particular attention be placed upon (1) whether the person has acted violently on the basis of this particular kind of delusion before, (2) whether the person's current delusional system incorporates any specific individual or targeted group (i.e. potential victims), and (3) the level of emotional investment and arousal the person has in relation to their beliefs and perceptions. We also endorse approaches that gather mental state information relating to the preceding few weeks, as well as the current time, so that any recent significant development over time or fluctuation in the consumer's mental experiences are more likely to be identified. For this reason, the associated toolkit focuses attention on both current and recent mental state experiences, an approach seen as having high practical relevance in conceptually related instruments, for example, the Chronological Assessment of Suicidal Events (Shea, 1998a, 1998b).

This additional guidance about aspects of mental state examination especially relevant to risk assessment addresses an important clinical point highlighted in the teaching resources associated with the toolkit. It is not necessarily an isolated mental state feature that drives violent behaviour; rather, it is important to detect important *combinations* of cognitive and emotional states. It is sometimes the meaning of particular mental experiences in specific situations that lead to people being violent. It is, therefore, crucial not to reduce risk assessment to the search for particular symptoms. To do so would be to fail to appreciate the dynamics between the person in their entirety and their social contexts (Wack, 1993).

The need to consider both historical and current or recent information relevant to risk assessment is emphasised in situations when the consumer does *not* have a significant history of violent or threatening behaviour but *does* present with mental state features strongly suggestive of serious risk to others. In this situation, clinical interventions towards safety for the consumer and others may be appropriate despite the absence of a history of such behaviour.

Pathways to Violence (Pattern Recognition)

The second stage in the risk assessment process is to make sense of the information gathered, so as to formulate an understanding of the pathways to violence for the consumer. This is a process of recognising patterns of particular relevance for the individual. It requires that the clinician and consumer look at the linkages between (1) the violent or threatening behaviour (e.g. what was the nature of what was done and to whom), (2) the circumstances or situation in which violent or threatening behaviour has occurred in the past, and (3) the indicators of that risk, both within the person themselves and within the situation. In effect, this mirrors the contextual approach identified in the first, information gathering stage, but emphasises the interaction of factors. This is a critical aspect of risk management because understanding the nexus or connection between a person's mental disorder or mental state and violent behaviour provides the basis for risk management. Without such an understanding, the risk management component of risk assessment is undermined (Mullen, 2000).

This relatively simple approach lends itself to effective communication between clinician and consumer, and emphasises the importance of developing a shared understanding of the pathways to violence within a therapeutic relationship. The framework can literally be used in talking to the consumer about risk issues. It can be shared and checked with other members of the therapeutic team, and with family members, if appropriate. If the discussion is positioned properly within the context of a therapeutic relationship, consumers often welcome the opportunity to talk about the sorts of situations that have led to violent outcomes in the past, and the things that might be noticed so that this can be prevented in the future.

The toolkit includes a semi-structured approach to pattern recognition attempting to improve the consistency and quality with which the formulaic task is approached. The semi-structured approach assists in highlighting relevant characteristics of past events and incorporates, in plain language, the different components of risk, including the likely nature of violence should it occur, the nature of the internal experiences for the person that are most likely to lead to violence (e.g. persecutory beliefs involving a specific individual), and the nature of the situational aspects that would make violence more likely (e.g. homelessness, social disconnection, illegal drug use or discontinuation of appropriate medication).

The output from this pattern recognition stage is the organisation of a wide range of information into a succinct, practical summary that captures the most important elements of the person's pathways to violent behaviour. The purpose of this formulaic stage is to generate a platform for shared understanding of the consumer's pathways to violence between the clinician, consumer, their family/whanau and other providers as appropriate, so that pathways to safety and recovery are enhanced and pathways to violence can be identified and avoided, if possible.

The toolkit also attempts to highlight or identify particular combinations of a person's presentation and social situation that signal a degree of urgency in terms of risk management processes. These particularly worrying situations should be discussed in some detail with the consumer and significant others involved in his or her risk management. If possible, an agreement should be reached about the sorts of interventions that would be necessary and useful in such a situation to keep everybody safe.

One appealing aspect of attempting to recognise patterns based on the circumstances and indicators of previous violent or threatening behaviour is that one does not necessarily have to determine a *direct* link between mental state features and violent behaviour (what might be called a mental mechanism) to manage risk. If one knows the circumstances under which violent behaviour occurs, and the indicators of that risk, then interventions towards achieving safety for all concerned can proceed. This is an important point in risk management because for many people, there is no direct link between the abnormal mental state and the acts of violence but an important, contributory, indirect influence can be identified (Blom-Cooper, Grounds, Guinan, Parker, & Taylor, 1996). An example of this would be a consumer who has acted violently in the past in the context of psychotic experiences, with the risk behaviour arising not directly from delusional beliefs or hallucinatory experiences, but indirectly from the disorganising and disinhibiting influence of the experiences.

Pathways to Safety (Recovery)

Risk assessment must lead into risk management. Clinical care and recovery are enhanced when knowledge gained from the previous two stages is incorporated into the consumer's care plan. The toolkit includes a template designed to assist this process by focusing attention on particular aspects of the care plan concerned with safety issues. This does *not* replace the care plan but recognises that an important component of care planning is to provide a foundation of safety for the consumer and those that support him or her.

Many of the main components of risk management should have been identified and implemented within an adequate care plan, for example, treatment of symptoms of mental illness with appropriate medication. However, the basic contextual approach and structure used in the toolkit, which focuses attention on aspects of the consumer's situational and internal experiences that are thought to underpin risk behaviours, suggests that three additional clinical tasks are important for the purposes of risk management (over and above standard care planning), in establishing pathways to safety and recovery.

First, consideration should be given to *sharing* the understanding of the pathways to violence developed in the second stage of risk assessment with significant others. This initially involves the consumer as part of the therapeutic relationship. Decisions to share this understanding beyond this relationship should obviously be discussed with the consumer and requires balanced consideration of issues

pertaining to confidentiality and the duties to protect. Information sharing with the whanau/family and members of the extended care team may be appropriate.

Second, clinicians should consider whether, given their understanding of the consumer's pathways to violence, the immediate context is such that *immediate safety issues* arise, over-riding other considerations. Depending on the context, this may involve a variety of responses, from discontinuing an unsafe interview situation, to arranging hospital admission for the consumer.

Third, the care team should focus attention on engaging the consumer in terms of a few main clinical *risk-reduction strategies*. One important strategy is monitoring for early warning signs, which may indicate that the consumer is moving down a pathway towards violence. This involves a clear description, developed and shared with the consumer, of the main clinical signs and situational factors observable in the lead-up to previous violent behaviour. Several factors will determine how much scrutiny is placed on a monitoring framework, including the likely seriousness of violent behaviour (should it occur), and the speed of relapse of the relevant mental illness. Often whanau/family are among the first to detect early warning signs and expressions of concern from those close to the consumer should be taken seriously.

In addition to a monitoring framework, the shared understanding should also generate other *specific strategies* that divert the consumer away from pathways to violence. For example, clinical interventions might focus on the provision of suitable accommodation, avoidance of substance abuse, compliance with medication where appropriate, targeted treatment interventions and social skills training. Other strategies will focus on the development of consumer resilience and strengths that are protective against violence, such as the capacity for productive work.

An important crucial aspect of developing such pathways towards safety is individualising the strategies employed to reduce risk. It is not difficult to generate a set of generic strategies or interventions that are broadly applicable to a wide range of consumers, such as attending to drug and alcohol issues or accommodation issues, but generic descriptions are likely to have limited clinical value. The risk management component of care plans, as for other aspects of the care plan, should be tailored to the consumer's individual needs and circumstances. It is the process of translating broad, generic descriptions into more specific, personalised care plans that is likely to support the therapeutic relationship and to provide effective mental health care and risk management.

General Points

An explicit framework helps communication between services. It is an accepted part of good clinical practice that, in certain situations, requests should be made for second opinions, an important consideration in the area of risk assessment and management. This may constitute a referral to a specialist or forensic service. The framework allows the referring team to conduct their own risk assessment, so that the specific reason for referral is clear and based on accurate information.

The core risk assessment process as outlined here can be supplemented with standardised instruments, as necessary, for example by specialist or forensic services. This introduces the tiered model of risk management. Our survey of different approaches in different countries indicated that the HCR-20 is the most popular instrument used in this fashion.

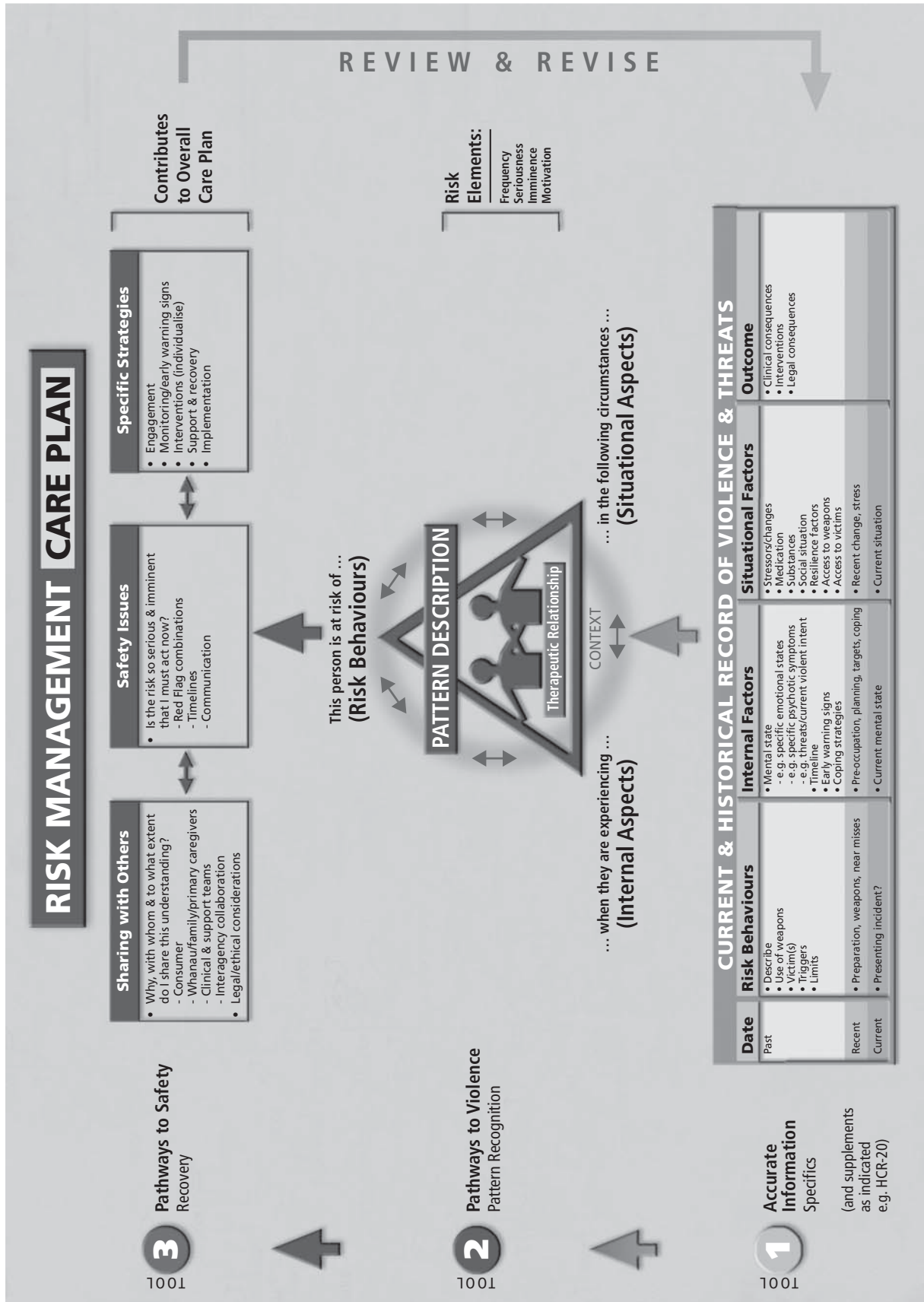
The one-page map on the following page provides a visual summary of the whole process (see Figure 1). The overall risk assessment process and the proformata that are used are deliberately relatively simple in appearance. It is true that in some instances (e.g. people with extensive histories of violent behaviour in various circumstances), the risk assessment process will be more complex than for other cases. However, even for such complex situations, the central framework for the toolkit is the same in terms of a simple and effective way for organising and thinking about the information. The hard copy of documentation remains user friendly and relevant.

The structured nature of the risk assessment process lends itself to the development of examples of relevant documentation, a critical part of the overall process. Services that require guidance about appropriate documentation will be able to use the example produced as reference points.

The conceptual framework, and indeed the various tools that have been developed, reflect the same clinical skills and practices that competent practitioners utilise in many mental health settings.

We are hopeful that the approach that is advocated here will lead to accessibility, clarity and increased participation in the risk assessment and management process. The goal is to assist in making the concepts of risk management and safety an integral part of clinical care and recovery for consumers of mental health services.

Figure 1. One-page map of the violence risk assessment and management process.



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Appendices

Appendix 1: Steering Group

Dr David Chaplow

Dr Jeremy Skipworth

Dr Phil Brinded

Jon Royal

Dr Rees Tapsell

Appendix 2: Web-Based Search for Guidelines

In addition to searching in traditional literature search engines, we undertook a search on the internet to attempt to find other governmental guidelines. We performed a search on www.google.com, inserting the phrase, 'guidelines on assessment of risk for violence in mental health'. We obtained 196,000 publications, not all of which we read.

We reviewed the first 200, which usefully included a library resource from the University of Adelaide entitled Mental Health and Psychiatry Practice Guidelines (www.library.adelaide.edu.au). Under the heading 'violence' within this resource, there were nine sites, two of which related to family violence, one to trainee safety, and one to a paper that we had already obtained via Medline. Three of the remaining papers were of particular value.

1. Council Report CR80.(2000). Good Medical Practice in the Psychiatric Care of Potentially Violent Patients in the Community. London: Royal College of Psychiatrists. This was an overview of similar scope to the 1998 New Zealand Ministry of Health guidelines, with the helpful addition of a section on relevant law.
2. College Research Unit. (1998). Management of imminent violence: Clinical practice guidelines to support mental health services. Occasional paper OP41. London: Royal College of Psychiatrists. These are extremely comprehensive clinical practice guidelines on assessing and managing (in the main) inpatient violence, and are the best of this type of guideline we have seen. The paper systematically reviews restraint, seclusion, environmental impacts, medication, acute prediction, and other national guidelines. The authors list good practice across clinical care, including short-term prediction, but does not set out a guideline structure for clinical technique, which is what we are attempting to develop in this guideline.
3. Wright, S., Gray, R., Parkes, J., & Gournay, K. (2002). The Recognition, Prevention and Therapeutic Management of Violence in Acute Inpatient Psychiatry. United Kingdom: United Kingdom Central Council for Nursing, Midwifery and Health Visiting. This is a very comprehensive literature review of the area of violent behaviour, focussing on interventions that are commonly employed in mental health services, and includes discussion of key ethical issues. Includes patient, staff and environmental issues and efficacy of interventions, as well as useful pointers to aspects of intervention. A comprehensive resource worth referring to.

Appendix 3: Request for Protocols and Documents

The following is the text of an email sent from Dr Sandy Simpson to all clinical directors and directors of area mental health services in New Zealand, on 20 April 2004.

Dear Colleagues

As some of you may be aware, the Ministry of Health has commissioned a review of the Risk Assessment and Management on Risk to others Guidelines of 1998. We have been asked to produce a training tool kit that can then be used nationally to assist teams assess and manage risk effectively. We will attempt to specify levels of training appropriate to different groups of mental health workers and covering different contexts [from CATT teams and CMHCs to forensic services].

We have established a team of Drs Ceri Evans, Verity Humberstone, Sylvia Van Altvorst, Renata Wack, Brian McKenna and myself, through the University of Auckland, to complete this task. The process will be peer reviewed and consulted with the sector, via a reference group established by the Ministry of Health.

To assist us in this work, we would greatly appreciate information on the policies and procedures employed in your services in relation to risk assessment and management for risk to others. We are wishing to build on and integrate best practice models, not reinvent wheels. So please send any material employed in your service, which you feel is successful and would help us in this work. Any comments you would like to give to us on this area would also be appreciated.

If you could please send those in the next 2 weeks [electronically is fine] we would greatly appreciate your input.

Yours sincerely,

Sandy Simpson

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Appendix 4: Glossary

Karakia	Prayer or blessing
Kaumatua	Respected elder
Kawa	Protocol
Kuia	Elder (woman)
Mate Māori	Māori illness
Matakite	Seer
Mirimiri	Massage
Rongoa	Traditional physical remedies
Tangata whaiora	People seeking wellness or recovery, mental health service user
Tikanga	Custom, obligation or meaning
Tohunga	Person with expert knowledge
Whakawhanaungatanga	Wider relationships or connections
Whanau	Consumer's family or extended family or group of people important to the consumer