

**Assessment and
Management of
Risk to Others
Trainer's Manual**

2006

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Disclaimer

The information contained in this publication is intended to assist but not replace the use of sound clinical judgement when assessing the risks of violence occurring. The Mental Health Workforce Development Programme, Ministry of Health, Auckland UniServices Limited and any contributors to this workbook accept no responsibility or liability for errors or adverse consequences arising from the use of information contained in this publication.

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Programme

	Activity	Duration	Time
1	Introduction	60 minutes	9:00
2	Scenario 1	60 minutes	10:00
3	Break	15 minutes	11:00
4	Toolkit: overview	45 minutes	11:15
5	Scenario 2 (inpatient component)	60 minutes	12:00
6	Lunch	60 minutes	1:00
7	Scenario 2 (outpatient component)	60 minutes	2:00
8	Break	15 minutes	3:00
9	Scenario 3	60 minutes	3:15
10	Scenario 4	15 minutes	4:15
11	Review and feedback	30 minutes	4:30
12	Close		5:00

Preparation for trainers

The following materials should be prepared or obtained prior to the commencement of the workshop.

1. Trainer's manual.
2. Revised guidelines (for trainer's reference).
3. Copy of workshop PowerPoint presentation.
4. Participant's workbooks (one per participant).
5. Laminated one-page models (one per participant).
6. Set of tools 1 to 3 (full set per participant).
7. Set of completed tools for scenarios 2 and 3 (full sets for each participant).
8. Feedback sheets (one per participant).

Make arrangements for the following to be available for the workshop.

1. Appropriately sized room.
2. Laptop and data projector (or alternative viewing mechanism).
3. Whiteboard, whiteboard markers or pens, and wipes.
4. Refreshments for during breaks.

Each region will decide upon the number of attendees for each workshop. The workshop will require small group work (three or four people per group) and large group discussions, so that overall group size should be limited to 12 to 16 participants where possible.

Begin on page 5.

Introduction

Trainers: Introductory text to the Trainee Workbook reads as follows –

Welcome to the workbook designed to support the toolkit training day for violence risk assessment and management for mental health services.

This booklet should be read in conjunction with the revised guidelines for violence risk assessment and management.

The toolkit is designed for use by all mental health services and across all professions. In particular, it is designed to assist general adult mental health services in the day to day requirement for violence risk assessment and management, although the framework presented here should also be applicable to specialist services (e.g. forensic services, intensive care teams) and for use by practitioners working with special groups (e.g. people with intellectual disability).

Although most people with serious mental illness do not act in a violent manner, violence risk assessment is an integral part of the ongoing provision of comprehensive and effective mental health care and can be informed by every contact between the consumer and a member of the mental health services.

This workbook focuses on the risk of violence to others but it should be understood that risk is a broader concept and can include risk to self, risk of financial or sexual exploitation, risk of relapse, risk to property and so on. The principles of risk assessment and management presented in this workbook are likely to be conceptually relevant for other aspects of risk. However, specific risk such as that involving sexual violence may require the use of supplementary instruments to guide risk assessment processes.

Trainers: workshop begins on page 5

- The workshop and workbook should be seen as part of an overall package, which, most importantly, includes the revised guidelines.
- The primary focus is on general adult mental health services.
- The workshop is not designed specifically for special groups (e.g. sex offender groups; people with intellectual disability), but may be still relevant (may need augmentation).
- The focus for the workshop is risk of interpersonal violence, rather than other risks (e.g. suicide).

Housekeeping

- Trainers: introduction and background
- Context: Ministry of Health initiative re violence risk assessment
- Use of workbook: personal use
- Photocopying and copyright issues
- Course duration and breaks
- Fire exits
- Involvement

Trainers: start here

1. A culturally appropriate welcome may be appropriate, depending on the context.
2. Introduce yourself by name and current position.
3. Give an overview of the group in terms of who is present and ask participants to introduce themselves.
4. State the purpose of the day in general terms.
5. Explain that the workbook is the participant's to keep, although there are limitations on copyright. State that your preference is for them not to jump ahead in the workbook, but to stay with the group as you work through it. They are likely to get more from the course this way and you would appreciate their cooperation in this respect.
6. Give an overview of the day in terms of start and finish times and breaks (refer to the programme outline on page 2 of workbook).
7. Deal with housekeeping issues, e.g. safety issues; location of amenities.
8. Make a comment suggesting that the benefit of the day is likely to be related to participants' willingness to be involved with the process. There may be some participants who are resistant to some issues related to risk assessment. Your role today is not to deal with various implementation issues but to deliver a workshop designed to increase the skill level of participants in terms of violence risk assessment and management.
9. Give some guidance about overall parameters on page 4 of workbook.

Goals and objectives

Terms of reference of current project

1. Review 1998 guidelines (Ministry of Health, 1998).
2. Survey current national and international practice in violence risk assessment and management.
3. Define competencies relevant for different mental health practitioners.
4. To lay the conceptual foundations for a violence risk assessment toolkit that can be used for training and service development.

Goals of training programme

- To be able to carry out a clinical violence risk assessment (**tools 1 and 2**).
- To be able to integrate this information into a comprehensive care plan to appropriately manage the risk of violence identified (**tool 3**).

Objectives of training programme

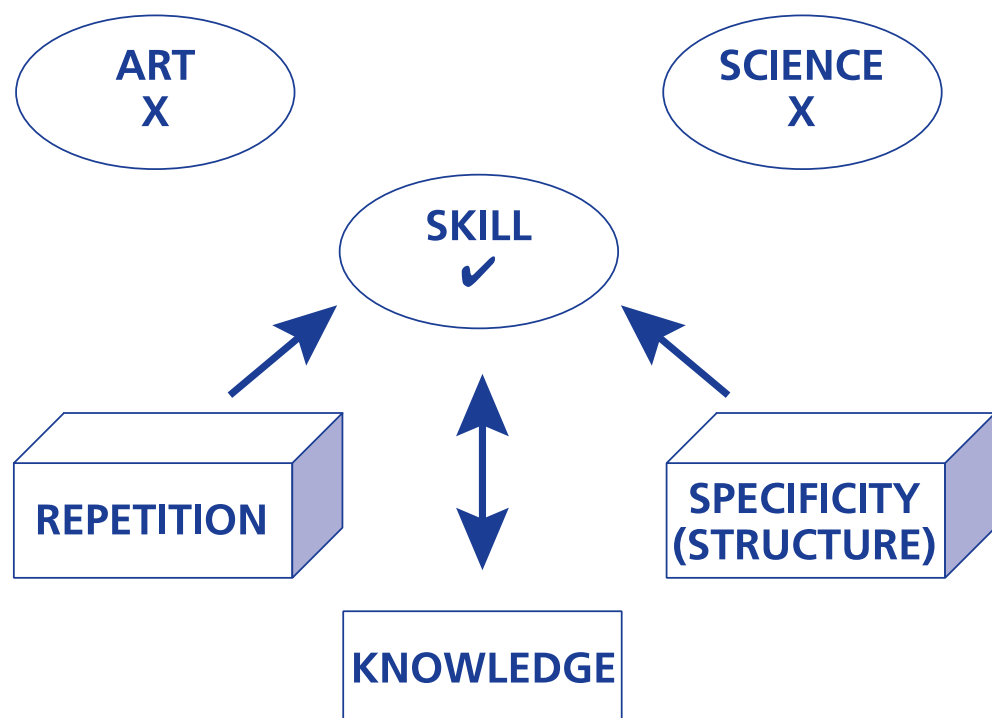
- To be able to identify the three main stages of the risk assessment process and to describe the main tasks at each stage.
 - To appreciate the importance of the therapeutic relationship for the risk assessment and management process.
 - To understand the place of violence risk assessment as an integral part of standard clinical practice.
 - To understand how to develop an individualised care plan in terms of appropriate tailored risk management strategies with which to engage the person.
1. Review the terms of reference for the overall project.
 2. Highlight the goals for the day, emphasising the practical nature of the desired outcomes (i.e. familiarity with the three tools and an understanding of their relationship to each other within the risk assessment and management framework).
 3. Introduce the four main objectives that support the overall goals.

Risk assessment: perspectives

Is risk assessment and management an art or science?

Develop the diagram below on a whiteboard in the following sequence of steps.

1. Draw up the art and science bubbles. Ask the group whether risk assessment is an art or a science?
2. Explain that the approach that will be taken today is one of **skill acquisition**. Draw the **skill bubble** in the middle. While there are elements of validity and truth in the art (e.g. the role of judgement) and science (e.g. the role of empirical risk factors) perspectives, the skill acquisition approach has several advantages (which you will now elaborate).
3. Ask the group to explain the **difference between skill and knowledge** (develop the theme of skill representing applied knowledge, i.e. doing something rather than an intellectual exercise). The course today will begin by reviewing some basic knowledge but will then concentrate on applying this knowledge (i.e. increasing skill in using specific tools).
4. Ask the group to state the two main determinants influencing skill development. Draw in the concepts or building blocks of **repetition**, and **specificity and structure**. Link this to the fact that several scenarios will be used during the course (= repetition) and specific tools will be used (= structure). Highlight the fact that you will *repeat* the main learning points throughout the day, in the spirit of skill acquisition (rather than irritation).
5. Link to next session: you will begin with a review of basic knowledge for one hour.



Myth and reality

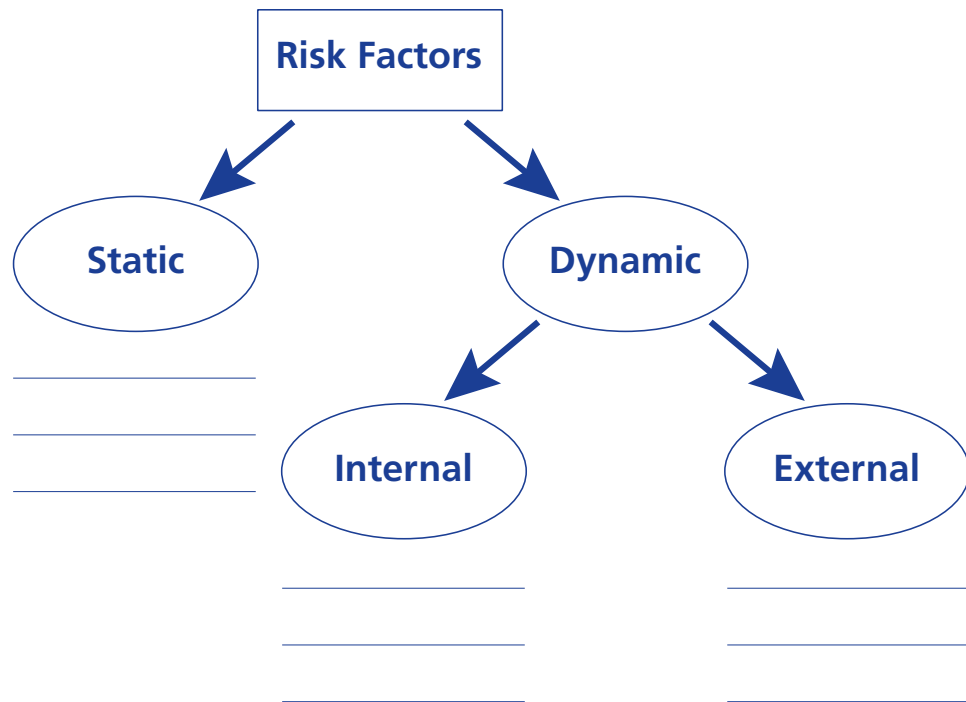
Decide whether the following statements about violence risk assessment pertaining to people with mental illness are true (T) or false (F):

Ask the group to spend about three or four minutes committing themselves to true or false answers for each of the statements. Work through each statement in turn highlighting the main learning points (45 minutes).

1. The most likely victims of violence by people with mental illness are whanau/family members. T / F
 - This is generally accepted as accurate. The purpose of putting this question first is to set a context. Although we are dealing with a clinical process, violence affects a broad range of people, sometimes in devastating ways. Refer to the cover design. The impact of violent episodes should not be forgotten as the focus of the course turns to the clinical process.

2. Most violent behaviour by people with mental illness is predictable. T / F
 - There are three main areas to develop in response to this question.
 - First, see it as a trick question, to some extent: draw out the theme from reviews of homicide inquiries that the majority of homicides by people with mental illness were not considered predictable, but the majority were considered preventable by the provision of adequate, competent clinical care. Therefore, a foundation of risk management is good clinical care (refer page 10).
 - Second, acknowledge that people do spend time, of course, trying to predict violence. Spend time developing a tree diagram (see below) of the various empirical risk factors for violence by people with mental illness by raising the question, "On what basis do people make such predictions about violence by people with mental illness?"
 - (1) First draw up the **static versus dynamic branching**, position this as the traditional way of categorising risk factors for violence, and define each term.
 - (2) Elicit a list of **10 static risk factors** from the group.
 - (3) Then position a key division used by the current approach by drawing out the **second branching** (i.e. the internal factors and the situational factors).
 - (4) Elicit a list of **10 internal (mental state) factors** from the group.
 - (5) Elicit a list of **10 situational (external or circumstances) factors** from the group.
 - (6) Review the overall diagram, pointing out that this is a summary of the main empirical risk factors for violence for people with mental illness. This knowledge will be applied to individual cases during the workshop.

Please refer to diagram below. Use the lists on pages 14 to 16 to assist you in drawing out the various lists underneath each of the headings.



- Third, draw out the three main approaches used for violence risk assessment (i.e. actuarial, unstructured clinical, and structured [or guided] clinical). Explain the strengths and weakness of each (see page 17). Position the tools used in the current course as representing the application of knowledge of empirical risk factors, that is, a structured clinical approach. The current approach also supports the augmentation of clinical tools with actuarial approaches, where relevant.
3. There are key symptoms of mental illness that predict violence. T / F
- Emphasise that it is a restrictive approach to focus too much on identifying specific symptoms, although acknowledge that in certain contexts some symptoms are very important. Combinations are important, both of mental state and situational factors, and, within the internal aspects category, of certain mental state features together (e.g. cognitive and emotional elements).
 - For example, many people with mental illness have persecutory delusions or command hallucinations but are not violent, and, those that are violent, are not violent most of the time. So, what is it about the internal experiences and social situations of these people that can precipitate violent behaviour? Emphasise the combination or interactive elements (e.g. not just the persecutory delusion, but a person living in a particular social setting). Emphasise the emotional tone or arousal that it is linked to (e.g. delusions or hallucinations). Highlight that the person should not be lost in the risk assessment process (i.e. it is not an academic exercise).

4. If antisocial or violent behaviour occurs when active symptoms are not obvious, the violence must arise from the individual's personality. T / F
- The main point to draw out here is that often there is no direct link between symptoms and violence in people with mental illness. Draw out the difference between **direct** effects of the symptoms (e.g. violence in response to persecutory delusions or command hallucinations), and **indirect** effects of psychosis (e.g. violence arising in the context of increased irritability, poor judgement, impulsivity, poor decision-making).
 - Therefore, just because no direct link with psychotic symptoms and violence can be immediately identified, this does not mean that psychotic symptoms were unimportant in the generation of violent behaviour, and, by implication, the violence is therefore necessarily linked to a person's personality. Often important indirect effects of psychosis become more obvious in retrospect when people with psychotic disorders respond well to antipsychotic medication and a pattern of violent behaviour is stopped.
5. The best predictor of future violent behaviour is past violent behaviour. T / F
- This is a well-rehearsed maxim. However, it has weaknesses.
 - First, it loses the contextual elements to violence, which are critical if useful clinical interventions are to be achieved. Just because someone has acted violently in the past, does not mean they continue to pose an equivalent risk in all situations in the future. This leads us back to concepts such as dangerousness, which have the capacity to label and stigmatise.
 - Clinicians have been criticised for overvaluing mental state features associated with violence and undervaluing the situational aspects.
 - It may be more useful to state that "the best predictor of future behaviour in certain contexts is past behaviour in similar contexts" (contexts meaning internal and situational elements).
 - Second, this approach obviously fails when it comes to handling first episodes of violent behaviour. If you are faced with a situation where a person has certain internal and situational elements strongly suggestive of imminent violence, it is not reassuring that they have not acted violently before.
6. It is the role of forensic practitioners to undertake violence risk assessment and management, rather than general adult mental health services. T / F
- It is the responsibility of all mental health practitioners to partake in the process. Of course, some contexts (e.g. forensic settings) will place significant attention on risk assessment.
 - There may be differences in terms of depth, but essentially forensic and general adult mental health practitioners undertake the same risk assessment process. They do not undertake different activities from a conceptual point of view. The framework to be developed today can be used by all mental health practitioners. Put another way, forensic practitioners do work with, in general,

people defined at least partly by the higher relative risk that they pose to others, but there is no special or magical risk assessment process that they have or use. They may use additional instruments (e.g. the HCR-20), but this does not replace the basic structured clinical risk assessment process.

Time check: You should be about one hour into the course. Next, turn to scenario 1 (Alice), which should be completed in about one hour. Remind the group that you will break for a short period after the first scenario.

Lessons from inquiries

Reviews of homicide inquiries relating to people with mental illness in the United Kingdom and New Zealand have drawn similar conclusions in terms of the most common identifiable flaws in the violence risk assessment and management processes when such tragedies have occurred:

1. Poor communication.
2. The failure to take the reports of others seriously.
3. Undue emphasis on a narrow concept of liberty.
4. Tendency towards cross-sectional assessments.
5. Failure to share information.
6. Failure to use compulsory treatment.

Key point

A greater proportion of incidents of violence by people with mental illness are *preventable* rather than *predictable*.

- [Refer to this point in Myth and Reality, question 2.](#)

Static risk factors for violence

Static risk factors for violence are those factors that either do not change over time or are relatively stable.

1. Male gender.
2. Age.
3. Childhood maladjustment and behavioural problems.
4. Childhood abuse.
5. Lack of educational achievement or truancy.
6. Employment problems.
7. Previous pattern of violence and aggressive behaviour.
8. Young age at first violence.
9. Previous incarceration.
10. Personality disorder, e.g. psychopathy, narcissism.

Produce a similar list to this under the heading Static by using the tree diagram structure outlined in Myth and Reality, question 2.

Internal risk factors for violence

Internal risk factors are those risk factors related to the person's mental state. They can be considered to be located within the person.

1. Current stated intent or threats to commit violence.
 - Thoughts.
 - Intent.
 - Plans.
2. Delusions.
 - Persecution (threat).
 - Control or passivity (control override symptoms: the person experiences a loss of control over their thoughts, feelings or actions).
 - Jealousy or love.
 - Grandiose.
3. Hallucinations.
 - Command hallucinations, especially religious in nature.
4. Final common pathways.
 - Paranoid thinking.
 - Irritability.
 - Impulsivity.
 - Ego threatened or disrespected.
5. Emotional states.
 - General level of arousal.
 - Anger, rage or righteous indignation.
 - Blunting.
 - Fearfulness.
6. Suicidal thoughts.
7. Confused states.
8. General attitudes.
 - Antisocial attitudes, e.g. lack of empathy, remorse or guilt.
9. Lack of insight.
10. Lack of empathy for past victims.

Produce a similar list to this under the heading Internal by using the tree diagram structure outlined in Myth and Reality, question 2.

Situational risk factors for violence

Situational risk factors are risk factors concerned with the person's social situation, life circumstances or context. They can be considered external to the person.

1. Lack of engagement with mental health services.
2. Substance abuse, intoxication or withdrawal.
3. Non-adherence to with medication (where relevant).
4. Stressful, poor or inadequate social situations.
 - e.g. power supply cut off.
 - e.g. loss of accommodation, homelessness.
 - e.g. overcrowding.
 - e.g. relationship difficulties, interpersonal conflict.
 - e.g. financial stress.
5. Major life events.
6. Exposure to destabilisers.
 - e.g. violent sub-culture.
7. Systemic problems.
 - Lack of coordinated care plan.
 - Lack of information sharing.
8. Access to weapons.
9. Access to potential victims.
10. Poor social supports.

Produce a similar list to this under the heading Situational by using the tree diagram structure outlined in Myth and Reality, question 2.

Approaches to risk assessment

1. Unstructured clinical judgement approach.
 - Based on experience.
 - Reliability issues.
2. Actuarial approach.
 - Statistical approach to generate category of risk.
 - Applies to populations rather than individuals.
 - Emphasises static and historical factors.
 - Research conducted on high-risk populations, so issues of applicability.
 - Base-rate issues.
3. Structured (guided) clinical judgement.
 - Systematic approach to information gathering and decision-making.
 - Based on empirical evidence.
 - Emphasis on understanding patterns.
 - Provides opportunity for clinical interventions.
- Unstructured clinical approaches tend to be used by individuals who are not operating within a well-developed or structured system or multidisciplinary framework.
- Actuarial approaches tend to be used by forensic services and some specialist services, e.g. sex offender treatment programmes.
- Structured clinical approaches tend to be used by services that have developed a standardised method of approaching violence risk assessment and management, within a culture of clinical governance.

This information provides a structure for developing the third point for Myth and Reality, question 2.

Scenario 1: Alice

You are working for the crisis team and you have been asked to assess Alice.

Alice is a 35 year old Pakeha woman who is brought into the emergency department by the police. Alice called the police saying that someone has broken into her flat. When they arrived, there was no evidence of a break-in and Alice started discussing how she was monitored by the neighbours through invisible cameras and that her tap water had been poisoned, which she could tell by the odd smell that was oozing through her taps. The police persuaded Alice to come into hospital by telling her it was "somewhere safe to go".

When you introduce yourself to Alice she appears aroused and fearful. Her knuckles are clenched and she is pacing up and down the room. When you identify yourself as being part of the mental health team Alice becomes angry and states, "I suppose you are going to tell me it's in the head!"

As you proceed with the interview, Alice discloses that she has been living alone for some years and that she frequently moves for fear of her safety. Before she had obtained her current flat, she had been homeless for one month. When you ask about any family or friends she says that her sister lives in the same city but she has not talked to her since she, "got me locked up in hospital last year". She described being in danger but will not tell you the details of who is involved. She says that she has to protect herself and takes out a pocket knife from her jacket but then puts it away.

What approach to interviewing Alice would you take?

Overview

The purpose of the first scenario is not to introduce the tools themselves but to establish the conceptual framework for the tools via clinical discussion in small and large groups. This will lay the foundation for the introduction of the one-page map and the tools in the next session.

The first task is to position the use of tools within clinical reality. Tools are just that; aids that can be used to support the clinical process. There are decisions to be made, based on clinical judgement, about the appropriate timing and use of tools.

Attention must, first and foremost, be placed on establishing a safe environment for all concerned and conducting the interview in a skilful fashion, so as to have the greatest chance of building a therapeutic relationship with the consumer. To put it rather obviously, care must be taken as to how the tools should be used. The clinician should not walk into an interview room with a narrow focus on completing a set of tools. The tools represent the output of a way of thinking, which is of greater importance than the tools themselves.

Some possible responses to the question.

- Clarify who you are and the purpose of assessment.
- Ensure that there is a ready exit from the room for yourself and Alice so neither of you are trapped behind furniture.
- Address the issue of the knife directly. Be clear that it is not a safe circumstance for you to interview someone with a weapon and ask her to hand this in.
- If she is unable to do this or becomes more distressed, then assistance from other staff members may well be necessary.
- A place of safety for the assessment may be appropriate (e.g. at the local mental health unit rather than the emergency department), depending on the set-up of the services.
- When these safety issues have been addressed, allow Alice to speak freely and have a sense of control about how she is disclosing information.
- Empathise with the frightening nature of what she is experiencing (emotional gate involving fearfulness).
- Ask if she would like anyone to be contacted at this stage as a support for her.
- Consider whether there are any cultural aspects that should be considered.
- Clarify key areas in Alice's mental state and history leading up to the presentation.
- Clarify intent to harm others and any intent to harm self.
- Clarify recent ability to self-care – eating, drinking etc.

Once these points have been made specifically in relation to Alice, spend time introducing interviewing strategy concepts described on the next page.

3. Emotional gates.

Engaging the person on topics that have emotional significance is more likely to lead to a productive conversation than rigid lists of mental state examination questions. The identification of these topics provides an entry or gate into more detailed questioning. For example, it is often helpful to begin with fearfulness because people are often more willing to talk about threats posed to them rather than any threat they may pose to other people. It is important to gauge the level of emotional arousal the person is experiencing. Gates relevant to potential violent behaviour include:

- fearfulness
 - anger
 - entitlement
 - interpersonal conflict
 - revenge
 - jealousy
 - hopelessness.
- Introduce the concept of interviewing via emotional gates rather than blindly reciting set mental state questions. This improves the development of empathy.
 - Ask the group to identify the main emotional gates leading to violence.
 - Work with the group to develop small cascades or sequences of questions for each emotional gate. Use Appendix 1 as a guide.

4. Question cascades.

Sequences of related or connected questions can allow a progression into critical direct questions.

- e.g. thoughts, intent or plans.
 - e.g. feelings and perceptions before, during and after the event.
 - e.g. perceived alternatives and consequences give sense of problem-solving ability and can indicate imminence or conviction to act a certain way.
- Emphasise the practical value of using sequences of questions that flow naturally on from one another (these can be called cascades of questions). A good example is the comparatively greater risk associated with an individual expressing thoughts, intent or plans of violence.

5. Direct questions.

Asking straightforward, unambiguous questions is a critical part of mental state examination. Statements of intent to harm others are an obvious and important indicator of potential violence.

- Current violent intent.
- Asking closed, direct questions does not necessarily increase the risk of such behaviour occurring.
- Highlight the importance of asking direct questions at some point in the interview (preferably in a sensitive way, using sequences or cascades of questions, as necessary).

6. Areas of specific concern.

- Persecutory delusions with respect to a targeted group or individual.
- Delusions of control or passivity symptoms.
- Command auditory hallucinations.
- Religious delusions with violent implications.
- Morbid jealousy.
- Current stated violent intent.
- Righteous anger borne of perceived psychological insult or slight.
- Although you will have already emphasised that it is usually more helpful to focus on combinations of mental state and situational factors, or combinations of emotional and cognitive factors, nevertheless there are certain mental state features that warrant specific consideration in relation to risk of violence. Make sure that the members of the group are aware of the importance of those areas of specific concern listed above.

Scenario 1: Alice (continued)

You retrieve Alice's psychiatric record from when she was admitted to the mental health unit last year. From this you discover that she has had 15 acute psychiatric admissions to four different mental health units over the past ten years, with a diagnosis of paranoid schizophrenia. In the current record, there is a statement that her first admission was precipitated by stabbing a taxi driver – no further details are given. At each admission, it seems there is a pattern of persecutory symptoms and a period of being lost to follow-up by the various community teams involved. On one admission, Alice had thrown a stone through the window of a next door neighbour and the police had been called.

What are the key areas that need to be clarified in order to develop a historical record that informs risk management and how should this information be summarised?

Overview

The series of questions relating to Alice are designed to engage the group in a clinical situation. The general method will be to generate lists of responses to the questions and then to highlight the importance of simplifying the nature of the information by structuring it in some simple way.

The purpose is not to show the group the tools at this stage but, via clinical discussions, to arrive at the conceptual structures, on which the tools are based.

Summarise the conceptual structure for each tool before moving onto the next question.

In response to the question above:

1. Generate a list of ideas from the group; the following list is given as an example.
 - What, specifically, have the violent incidents involved? For example verbal aggression, physical aggression, use of weapons?
 - Have there been other issues of risk (e.g. suicide attempts, sexual risk, victim of assaults or abuse, impact of homelessness, physical illness).
 - Who were the people the aggression was directed against (e.g. known or not known, people who had confronted Alice)?
 - Pattern of symptoms at time of relapse (e.g. always with persecutory delusions or are other key mental state phenomena present, command hallucinations).
 - What are the time frames to past relapses?
 - What model of community follow-up was used and how successful was this?
 - Have there been significant stressors or identifiable environmental factors contributing to relapse?

- Has substance abuse been an issue?
 - What protective factors have been present – both internal strengths and external supports?
 - What was Alice's response to treatments offered?
2. Point out that this level of detail can be overwhelming. It is useful to organise the information within a sub-structure. Ask the group to identify potential categories of information (in doing so generate and develop the four categories used in tool 1 (risk behaviour, internal aspects, situational aspects, and outcomes).

Scenario 1: Alice (continued)

You are the community team member who is following up and supporting Alice in her flat. It is now three months since her presentation to the emergency department.

Alice is no longer aroused and fearful and does not believe that she is being poisoned by neighbours. She is no longer carrying a knife. She is, however, uncomfortable around people and finds it difficult being in crowds such as at the supermarket. She has talked to her sister on the telephone but does not feel comfortable visiting her. Alice is a creative woman with artistic talent and is currently painting. She has not worked for several years and does not feel able to contemplate looking for work at this stage. She has been reluctantly taking risperidone 5mg daily but resents this. She does not accept that she has a mental disorder or that she requires treatment. She says that she only tolerates taking it and your visits because she is under a community treatment order and that she has considered stopping risperidone anyway.

1. How do you work with Alice on developing a therapeutic relationship?

- Working with Alice over time.
- Getting to know Alice as an individual and talking about things that are important to her (e.g. art).
- Establishing times for visiting and the preferred location for Alice. Regular contacts are important.
- Being available at times when things are more difficult or there is something that Alice wants to talk about with you.
- Offering practical assistance where necessary (e.g. helping with benefit or other practical supports).
- Offering assistance by way of strengthening other social supports (e.g. is there anything she would like you to do to help with her relationship with her sister)?
- Validating the impact of her experiences by careful and reflective listening.
- Supporting Alice with her goals.

2. Are any patterns recognisable in terms of pathways to violence?

- The purpose of this question is to get the group to think about how the information gained in the first stage of risk assessment (gathering information = tool 1) can be analysed. Put simply, the analysis can be usefully seen as an exercise in pattern recognition.
- Again, it is useful to categorise the information so that it can be simplified in a practical, succinct manner, without important information being lost. The structure that is recommended here is the same as that used for gathering the information, that is, risk behaviours, internal aspects and situational aspects.
- Is there a pattern in terms of the risk behaviour(s) exhibited?

- Are the same internal aspects present each time risk behaviours occur, or do they vary?
- Are the same situational factors present each time risk behaviours occur, or do they vary?
- In addition to factors that lead to risk behaviours, a balanced risk assessment also includes factors that make risk behaviours less likely. These are called protective factors. As for risk factors, it is important to consider whether there is a discernible pattern of protective factors that appear to have reduced or prevented the occurrence of violent behaviour.
- Summarise this section in terms of the three main aspects of the triangle that will form the conceptual basis for tool 2. Highlight the importance of the apparent simplicity of this approach. This is critical because clarity of communication within the multidisciplinary team and with Alice is vital to effective risk assessment and management.

Scenario 1: Alice (continued)

Alice has previously had poor outcomes with recurrent episodes of psychosis and periods of homelessness and hospitalisation. This has caused a significant impact on her life and her relationships with her family. After hospitalisation, Alice would generally have a short period of community stability keeping in contact with the mental health services and taking antipsychotic treatment, although this was not sustained. She had been discharged from the community mental health team she saw prior to this relapse to general practitioner care after she failed to attend three clinic appointments. Alice did not contact either the general practitioner or mental health services again until her presentation to the emergency department.

As the community team that has been working with Alice since her last relapse, what strategies can be developed that will provide pathways to safety and recovery?

1. Generate a list of possible strategies; the following list is given as an example.
 - Therapeutic relationship – value Alice’s strengths and abilities and get to know her as an individual.
 - Continuity of care.
 - Ensuring ongoing adherence to risperidone.
 - Continuing community treatment order for as long as necessary to ensure compliance.
 - Follow-up actively if not attending appointments.
 - Provide practical help and support.
 - Be responsive when contacted.
 - Support the development of relationship with sister and be available for sister if she contacts with concerns.
 - Discuss with Alice ways of staying well, and review with her how she was when she did stay well compared to what was happening when things went wrong.
 - Help develop a shared understanding of experiences.
 - Be very clear on the role of antipsychotic medication but be sensitive to the need to listen to side-effects or any problems with the medication.
2. The purpose of this question is to highlight the importance of (1) identifying particular strategies for managing risk with Alice, and (2) making sure that these strategies are not generic (very general principles that are applicable to many people) but are specific and individualised (i.e. they have meaning for Alice and her personal situation).

Toolkit: one-page overview

Please refer to the one-page model on the next page detailing the violence risk assessment and management process, which you will find in the review of the guidelines document. Consider the following points about the overall framework.

1. Three stages.

- (1) Accurate information: specifics.
- (2) Pathways to violence: pattern recognition.
- (3) Pathways to safety: recovery.

2. Risk management contributes to the care plan.

- It is a part of it.
- It does not constitute all the care plan.
- It does *not* sit outside of the care plan (conceptually).
- It may influence other components of the care plan.

3. Review and revise.

- The risk management process must be reviewed and revised as appropriate, e.g. set review intervals, incidents, situational changes.

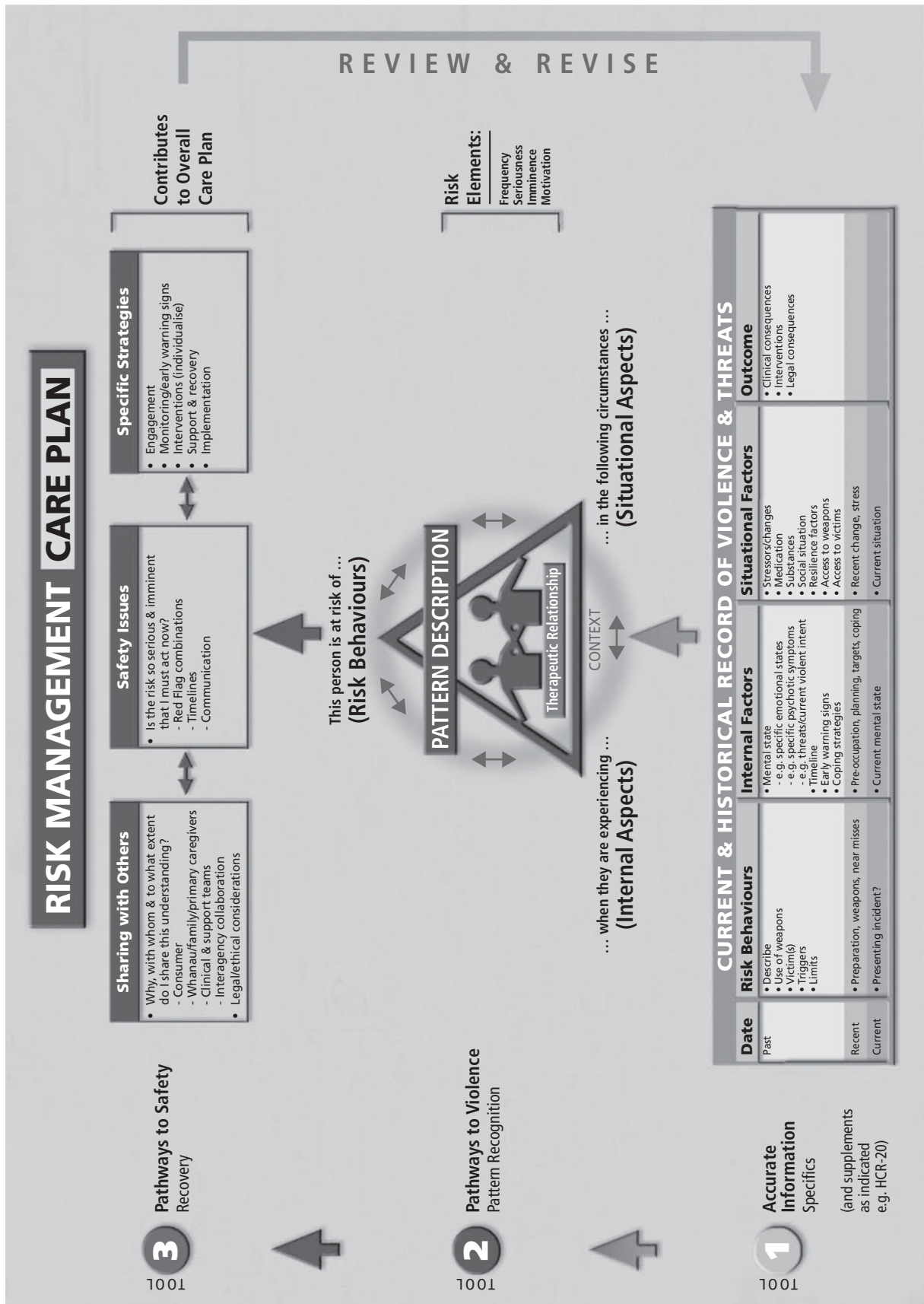
4. Augmentation.

- The structured clinical process can be supplemented if necessary, with actuarial or structured tools.
- HCR-20 is the most commonly used instrument for this purpose.
- Liaison with forensic or specialist services.

Overview

The purpose of the next section is to introduce the conceptual overview in the format of the one-page map, and to introduce each tool, on the back of the clinical discussion arising from scenario 1. You have 45 minutes to talk through the structure of each element and to respond to questions.

- Give out the one-page models and copies of each tool to each participant.
- Go through the points listed above to provide an overview of the role of each tool and how it all links together.



Tool 1: accurate information (specifics)

1. Current and historical record of violence and threats (locate on map).

CURRENT & HISTORICAL RECORD OF VIOLENCE & THREATS				
Date	Risk Behaviours	Internal Factors	Situational Factors	Outcome
Past	<ul style="list-style-type: none"> • Describe • Use of weapons • Victim(s) • Triggers • Limits 	<ul style="list-style-type: none"> • Mental state <ul style="list-style-type: none"> - e.g. specific emotional states - e.g. specific psychotic symptoms - e.g. threats/current violent intent • Timeline • Early warning signs • Coping strategies 	<ul style="list-style-type: none"> • Stressors/changes • Medication • Substances • Social situation • Resilience factors • Access to weapons • Access to victims 	<ul style="list-style-type: none"> • Clinical consequences • Interventions • Legal consequences
Recent	<ul style="list-style-type: none"> • Preparation, weapons, near misses 	<ul style="list-style-type: none"> • Pre-occupation, planning, targets, coping 	<ul style="list-style-type: none"> • Recent change, stress 	
Current	<ul style="list-style-type: none"> • Presenting incident? 	<ul style="list-style-type: none"> • Current mental state 	<ul style="list-style-type: none"> • Current situation 	

2. Time frames (all are required for a comprehensive, current risk assessment).

- Past.
- Recent.
- Current.

3. Chronology of violent or threatening incidents.

- Useful to detect escalation in frequency or severity.
- Useful for detection of patterns, e.g. victims, specific times, preceding events, etc.

4. Contextual information (additional useful information for interventions).

- Internal factors.
- Situational factors.

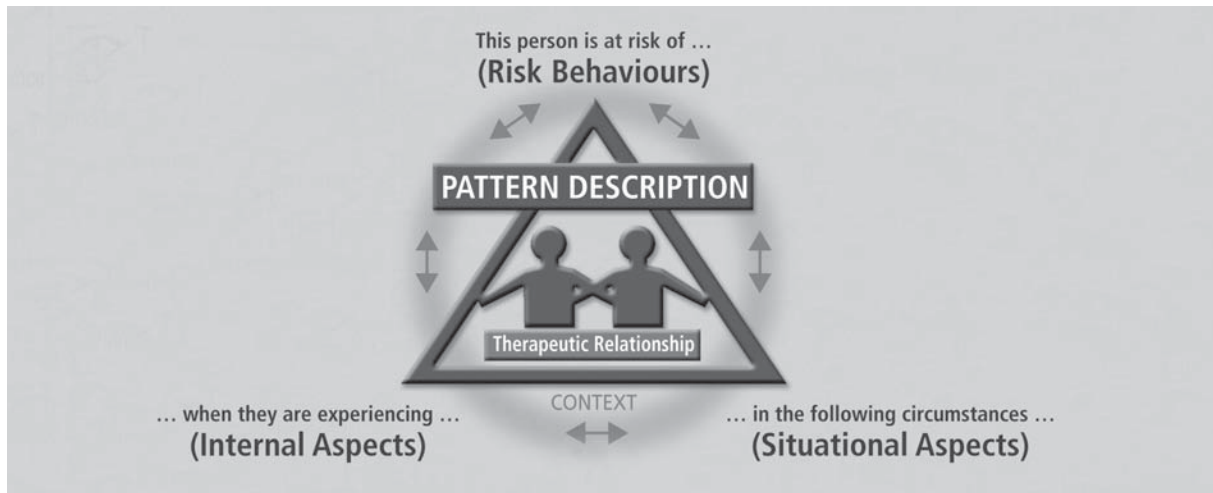
5. Sources of information.

- Principle of corroboration.
- Thoroughness.
- Information sharing or correspondence.

- Introduce tool 1. Link to the conceptual structure used in scenario 1.
- Go through each of the points listed above.
- Emphasise the importance of specifics (i.e. contextual information).
- Note that the map provides a graphic representation of the tool. Make explicit the links between the map and the actual tool.

Tool 2: pathways to violence (pattern recognition)

1. Pathways to violence (pattern recognition) (locate on map).



2. Risk behaviours.

- Accurate description (include planning or preparation activities).
- Weapons.
- Victims.
- Triggers.

3. Internal aspects.

- What does the person experience (perceptions, thoughts, feelings, sensations)?
- What do others observe?
- What is the timeline?
- What coping strategies does the person use?

4. Situational aspects.

- Stressors or changes.
- Social situation.
- Substance abuse.
- Medication discontinuation.
- Engagement with mental health services.

- Resilience factors.
- Access to weapons.
- Access to victims.

5. Pattern description.

- Do indicators vary over time?
- Do situational aspects vary over time?
- Are there different types of violence? (Consider whether there are different victim groups and whether this reflects different underlying motivations).
- “At its simplest, risk assessment involves two stages: the context in which risk increases, and the symptoms and signs which indicate that risk. For its part, risk management relates to the interventions which contain or reduce risk” (Berkshire Health Authority, 2002).
- It is not necessary to have a clear link between internal aspects, situational aspects and risk behaviours to manage risk.

6. Therapeutic relationship.

- The triangle provides a structure that can be used in talking about violence within the therapeutic relationship.
- Introduce tool 2. Link to the conceptual structure used in scenario 1. Use the prompts on the following page to assist with the discussion.
- Go through each of the points listed above.
- Emphasise the importance of pattern recognition.
- Note that the map provides a graphic representation of the tool. Make explicit the links between the map and the actual tool.
- Emphasise the central place (in graphic terms) and importance of the therapeutic relationship in terms of the risk assessment and management process.

Tool 2: complete the sentence...

One way of improving the consistency and reliability of risk assessment pattern description (formulation) is to use a semi-structured approach, which requires the clinician to complete question stems.

1. This person is at risk of ...

- risk behaviours
- use of weapons
- likely victims.

2. ... when they are experiencing ...

- internal experiences
- objective signs (including early warning signs)
- speed of relapse.

3. ... in the following circumstances ...

- e.g. stress, change
- e.g. living situation
- e.g. medication adherence
- e.g. substance abuse
- e.g. access to weapons
- e.g. access to victims.

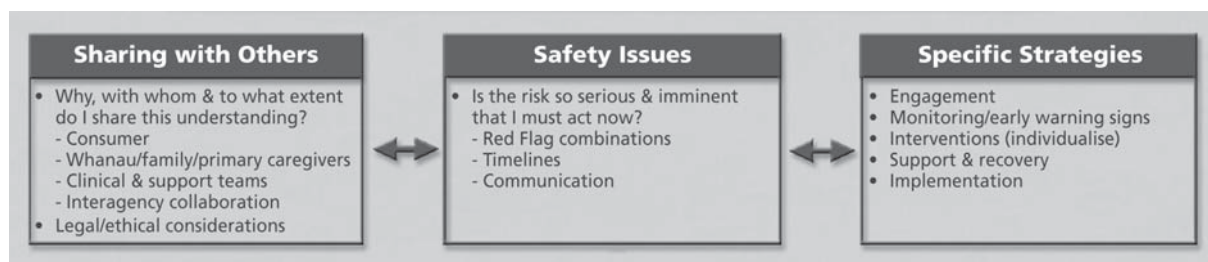
4. The following act as protective factors ...

- e.g. meaningful daytime activity
- e.g. support from extended family/whanau
- e.g. regular contact with key worker.

Note: Appendix 2 has more detailed lists of questions and prompts that might assist the clinician in thinking about pattern elucidation. Ask the participants to turn to Appendix 2 so that they have seen the structure of the prompts.

Tool 3: pathways to safety (recovery)

1. Pathways to safety: recovery (locate on map).



2. Sharing with others.

- Balanced judgement (Health Information Privacy Code 1993, duty to protect).
- Primary supports (whanau, friends, caregiver).
- Main contacts (flatmate, employee, colleagues).
- Likely victims.
- Clinical services (MDT, crisis, inpatient).
- Support agencies (NGO, CSW).
- Community agencies (pharmacy, community probation services, police, GP or community health worker, community counsellors).
- Introduce the concept of balancing the rights of the individual to confidentiality and the rights of the public to be protected.

3. Safety issues.

- Should I act now? Today? This week? In due course?
- Acute responsiveness to those at acute risk of violence.

4. Specific strategies.

- The primary focus is engagement with the consumer, whanau and primary supports.
- Engagement can be constructive, informative or restrictive.
- Ongoing issue is the development and maintenance of therapeutic alliance.
- The basis for risk management is a well-considered care plan.

- Important components include accurate diagnosis, optimal treatment, regular monitoring for early warning signs and early intervention when these occur.
- Direct support to address situational factors that could lead to stress and relapse.
- What few main interventions should the clinical team focus their attention on when engaging with the consumer?
- How can the consumer be supported and assisted in their recovery?

5. Dynamic and individualised care plans: the secret to successful risk management.

- Tailoring general strategies to an individual's particular situation increases practicality and effectiveness.
 - When early warning signs are identified, what specific strategies need to be implemented (be specific including who will do what, when, how)?
 - Who is most likely to recognise early warning signs? It may not always be the consumer, particularly if insight is an issue. It may be a whanau/family member, caregiver, employer, school teacher, probation officer, caregiver, and so on.
-
- Introduce tool 3. Link to the conceptual structure used in scenario 1.
 - Go through each of the points listed above.
 - Establishing a safe environment is the first concern.
 - An important and sometimes difficult area of risk management involves the sharing of information.
 - Emphasise the importance of individualising strategies so that they are tailored to the person's own situation.
 - Note that the map provides a graphic representation of the tool. Make explicit the links between the map and the actual tool.

Tool 3: pathways to safety (recovery)

Care plans must be dynamic in nature. For example, what specific interventions or activities might be appropriate in the following situations?

The purpose of this exercise is to give examples of some relatively common situations and the need to individualise and revise care plans. Depending on the time you have available, this can be done as a large or small group exercise.

The following are guides for consideration and will not necessarily apply to every consumer who is treated by mental health services, particularly those with minor or time-limited conditions. They need to be considered because many consumers have had very poor health outcomes when they have not received active follow-up. For example, lack of engagement or drifting out of contact when there are signs of being in early relapse can result in homelessness, acute hospitalisation or situations of risk.

1. The person does not engage with mental health services.

- Discuss with the consumer and their family and supports what the issues are that have made engagement difficult.
- Is there some practical barrier to engagement (e.g. difficulties with transportation to appointments, or looking after young children)?
- Is there a barrier from how appointments are arranged? (e.g. sending appointments through the mail when the person may have ongoing symptoms that will make it difficult to remember appointments from an appointment card.)
- Has there been a specific issue of concern with a staff member or with the type of services they have been offered?
- From this discussion identify solutions to address lack of engagement.

2. The person stops taking medication.

- Discuss with the consumer what the barriers to adherence are and what their understanding is of the role of medication.
- Ask about whether there are any side-effects that are contributing to this decision and address these.
- Explore the effectiveness of the medication.
- See if there are any practical barriers contributing to the decision (e.g. cost, difficulty picking up the medication etc) and address these.
- Explore the attitude of family and significant others to medication and see if this has been a factor in the decision-making.
- Explore whether there are any cultural issues regarding the use of medication that need exploring.

- Discuss with the person their early warning signs of relapse and what role medication has had in their recovery.
- Ask if there have been issues of forgetting to take medication and whether prompts from family or blister packs may be helpful.
- If there are clear signs of relapse associated with not taking medication, help the person start medication again. This may involve staff visiting at home, offering time out in a respite facility or using family support.
- If there are serious issues of risk and signs of relapse, hospitalisation may be indicated.

3. The person is lost to follow-up.

- If he has missed appointments sent through the mail it is often appropriate to make contact through the telephone or home visits.
- Contacting family or other social supports to see if they are aware of the persons location.
- Contacting other agencies such as the person's GP or NGO worker.
- Alerting the after-hours staff that the person is missing can provide an alert if the person comes in contact after hours.
- Where there are issues of safety, if the person is lost to follow-up (e.g. leaving an acute unit) or becoming lost to services when in relapse, then contacting the police is appropriate.

4. The person is in early relapse.

- There may be a relapse prevention plan or advance directive to follow that indicate strategies to treat relapse.
- Assess the person's mental state.
- Assess any environmental factors that are contributing to relapse.
- Discuss with the consumer and their family and social supports strategies to reduce relapse.
- These include medication strategies (e.g. optimising type and dose of medication).
- Environmental strategies (e.g. presence of support people, visits from mental health staff, going to a different community setting, respite).
- Supporting the individual's strategies for dealing with relapse (e.g. taking time out from usual routine, stopping drugs).

Examples of individualised care plans

1. Early warning signs.

- Increase frequency of contact with individual.
- Increase contact with whanau or caregiver.
- Optimise medication.
- Ensure adherence.
- Address situational factors that may be contributing to relapse.

2. Adherence issues.

- Increase frequency of contact and monitoring.
- Elicit consumer's concerns regarding medication.
- Explore reasons for non-adherence.
- Provide psychoeducation about medication.
- Review and manage side-effects of medication.
- Prescribe only the most essential medication.
- Convenient arranging and scheduling of medication (blister pack medication, single daily dosing, deliver medication to home).
- Reduce complexity of medication regime.
- Arrange for medication to be supervised (utilise blood levels).
- Collaboration with whanau or primary supports to enlist their help to improve adherence.

3. Optimise medication regime.

- Consider increase, addition or change.

4. Provide structure and supervision (if necessary).

- Sub-acute or respite placement.
- Consider admission.
- Consider use of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- This page can be used as a small or large group exercise, depending on the time available. It provides examples of how care plans can be tailored to meet individual needs. This section can be omitted if time is short; it is similar to the previous exercise and there is some overlap.

Scenario 2: Jack (inpatient)

You are a staff member working in a busy community mental health centre. You have been referred Jack from Probation Services. Jack is a 32 year old Māori man who is on probation after being sentenced and serving time for illegal possession of a firearm. He is a high-ranking member of a nationally established gang. Probation services became concerned when Jack discussed hearing the voice of a policeman swearing at him and complaining that the police were monitoring his movements and telephone calls.

At interview, Jack clearly has persecutory delusions and auditory hallucinations involving the police and one particular officer. He has not confronted anyone over these experiences but feels it could come to this if he is not left alone.

He also has started to believe that his girlfriend has been cheating on him. He believes this because her body “feels different” when they have sex and because although he goes to sleep with his arm around her he always wakes up in a different position. He thinks that she may be unfaithful with men during the night in the same bed whilst he is sleeping. He has confronted his girlfriend and physically assaulted her on two occasions in the past two weeks. He has also made sure that he knows where she is at all times. Jack is distressed by his experiences and not sleeping well.

He has ready access to amphetamine and smokes this on a near daily basis. He also uses marijuana and diazepam to “bring him down”. His sister is under the same community mental health centre and is receiving treatment for schizophrenia. He has had past periods of imprisonment for rape, burglary and male assaults female. Occupationally he is actively involved in gang-related activity.

Use tools 1, 2 and 3 in sequence to develop a risk assessment and management plan (your facilitator will stop you after each tool has been used for review).

Overview

The purpose of scenario 2 is to give the participants a first opportunity to practice using tools 1 to 3.

Stop the small group work after they have had enough time to complete each tool and facilitate a large group discussion about the information that was entered on that particular tool.

- Divide the large group up into smaller work groups of three or four people.
- Give the group about 10 minutes to complete each tool.
- Stop the groups after each tool has been completed and use the completed tools in Appendix 3 to guide a large group discussion about the appropriate entries.
- Try to make sure that each group and the different members of each group are contributing.

Scenario 2: Jack (continued; outpatient)

Jack has been discharged to live with his girlfriend after a period in hospital. During hospitalisation he was treated with risperidone which reduced his psychotic symptoms substantially. At the time of discharge he had a minor level of auditory hallucinations "unclear mumbling", for short periods of time only. He had insight into this and it did not distress him. Jack was motivated to continue risperidone but was ambivalent about his future use of substances. Both Jack and his girlfriend were prepared to accept follow-up from mental health community services.

- Continue with the smaller work groups of three or four people.
- Ask the group to complete tool 3 for the community scenario.
- Use the completed tool 3 in Appendix 3 to facilitate a large group discussion about the appropriate entries.
- Try to make sure that each group and the different members of each group have the opportunity to contribute.

Scenario 3: Pouli

Pouli is a 25 year old Tongan man who is referred for community mental health centre follow-up after being discharged from an acute mental health unit in another district health board. He has been discharged to live with his oldest brother.

This admission was his first and it was precipitated by his chasing his sister with a machete after she confronted him about some of the things that he had been discussing with the family. He had been living with this sister and her husband for the past three years and over this time had become increasingly withdrawn and had stopped working in the supermarket in which he had been employed. He had started talking about having a special role as a eunuch for the King of Tonga, which meant that he had to protect young women from the sexual advances of other men. He also described hearing the whispering voice of the Holy Spirit, which confirmed that his special role was approved by Jesus. In the acute unit, he had been treated with 10mg of olanzapine for three weeks and then discharged.

You interview Pouli with his brother present. The family had moved from Tonga ten years ago and speak fluent English. Pouli's brother describes being very distressed and surprised by the recent events. He had been aware of changes with Pouli but does not understand why he has been in hospital or why he is now prescribed treatment. He describes the family as being upset and angry at Pouli's behaviour. The family are active church members and have never experienced contact with either the police or mental health services. Neither Pouli nor family members use alcohol or illicit drugs. Pouli had been taken to their minister for counselling prior to the assault.

Pouli himself was downcast during the meeting with little eye contact. He was unable to discuss the events leading to hospitalisation and stated that things were "fine now". He deferred to his brother to respond to the questions during the assessment but did state that he did not want to see his sister again and that he was not a criminal.

Use tools 1, 2 and 3 in sequence to develop a risk assessment and management plan (your facilitator will review after you have completed all three tools).

Overview

The purpose of this scenario is to give the participants a further opportunity to familiarise themselves with using tools 1 to 3. They should have less guidance as they prepare the tools in small groups. After about 40 minutes, facilitate a large group discussion in which the aim is to make sure that participants are entering the right sort of information in the correct tools (i.e. that they are using the tools correctly).

- Divide the large group up into smaller work groups of three or four people.
- The task for scenario 3 is to complete all of tools 1 to 3 before the groups are brought back into a large group discussion. Give the small groups about 40 minutes for this task and emphasise that they should try to take the exercise as seriously as possible.

- Use the completed tools in Appendix 4 to guide a large group discussion about the appropriate entries.
- Try to make sure that each group and the different members of each group have the opportunity to contribute.

Scenario 4: Zareena

Zareena is 28 years old, married and a mother of two children aged four years and nine months. She is a Fijian Indian Muslim woman and has lived in New Zealand for the past eight years. She is brought into the community mental health centre by her older brother and his wife. They say that the family first noticed a problem when she refused to accompany her husband three weeks ago to visit relatives in Fiji. In his absence, she and her children have been living with them and their young son.

They have noticed her behaviour becoming increasingly more unusual. She has been up during the night reciting prayers loudly and giggling to herself when she reads the Koran. Yesterday she described having a gift from God that would help infertile mothers everywhere. Her sister in law was shocked to find her dancing scantily dressed in the rain with her nine month baby being held to the sky to help a "holy transformation".

On mental state assessment, Zareena was restless and frequently left her seat saying that she had work to do. Her speech was pressured, loud and difficult to interrupt. She described feeling blessed and filled with joy. She described believing that God had chosen her for a holy mission of purification. She believed her nine month old son was a future prophet and he could communicate with her through her mind.

Zareena had no history of mental illness or substance abuse. She has no history of violent behaviour.

What are the implications for violence risk assessment and management for a person without significant history of mental illness or violent behaviour?

Overview

The purpose of scenario 4 is to present a case in which there is no history of violent behaviour or mental illness. There can be a tendency for clinicians to underestimate the risk of violent behaviour in these situations.

Run this session as a large group exercise. Rather than using the tools, the goal will be to facilitate a large group discussion, in which the combination of mental state (internal) features and situational elements combine so that the person presents a significant imminent risk of harm to others, *in the absence of* any significant history of violence.

Suggested point for discussion: what are the implications for violence risk assessment from an absence of previous violent or offending behaviour in a person's background history?

1. Need to be very clear on current mental state, particularly the following.
 - Presence of delusions; in Zareena's case they are grandiose and religious.
 - Presence of hallucinations; in this case to do with her son and God.

- Level of arousal with the psychosis; this is high in Zareena and associated with an elevated mood.
 - Level of preoccupation.
 - Whether the person has impaired judgement (i.e. whether actions are influenced by symptoms); in Zareena's case this is significant as she is clearly acting on her psychosis and this has involved her vulnerable baby.
2. Need to be very clear on the situational (environmental) risks.
 - Presence or absence of social support and a stable living situation.
 - Any identified people who are vulnerable to risk; in this case a baby and young child.
 - Any aggravating factors such as drugs or alcohol.
 - Any contributing medical conditions.
 3. Person's usual coping style.
 - How does the person usually cope with stress or difficulties?
 4. Clinical knowledge.
 - Are there any particular clinical aspects that help inform clinical risk assessment and management? For example in this case clinical knowledge regarding the assessment of postpartum or puerperal psychosis is relevant.

Learning points: risk management

1. Lack of progression from risk assessment into risk management.
2. Failing to define criteria and thresholds for review and to update previous risk assessment and management plan.
3. Lack of focus on violent behaviour (focusing instead just on illness factors).
4. Lack of focus on situational destabilisers.
5. Avoidance of difficult questions about violence.
6. Underestimating the role of psychosis in violence (based on the apparent lack of direct delusional drive or command hallucinations).
7. Not sharing information with other important people.
8. Failing to take assertive action to establish safety, when necessary.
9. Failing to listen to the consumer, when they are concerned about their potential for imminent violence.
10. Failing to listen to whanau, family and caregivers, when they are concerned about imminent violence.
11. Failing to take a longitudinal approach to risk assessment.
12. Failing to respond appropriately to early signs of relapse.

This is an opportunity to reinforce (repetition) some of the learning points that should have emerged during the day, or, if they did not, to cover them at this point. The goal will be to show that many of the failings of poor risk assessment processes could be avoided with appropriate use of the tools (alternatively, good practice could be facilitated by use of the tools), i.e. the goal is to show the practical relevance of the tools for good clinical practice.

One method of achieving this is to ask different members of the group to:

1. explain the relevance of each point; and
2. suggest how one or more of the tools might help to avoid mishaps.

Summary

1. There are three main stages of risk assessment and management.
 - Accurate information (contextual elements, corroboration, thoroughness, individualise general risk factors).
 - Pathways to violence (pattern recognition, individualised).
 - Pathways to safety (dynamic and individualised).
2. The therapeutic relationship is central to the risk assessment and management process.
3. Violence risk assessment is an integral part of standard clinical practice.
4. Engagement of the consumer should be based upon appropriately tailored, individualised and dynamic risk management plans.

You are now at the closing stages of the course.

The summary on this page is a repetition of the goals and objectives that you will have covered at the start of the workshop.

This represents a final opportunity to repeat the main learning points. A good way of doing this is to, again, ask different members of the group to explain the points to the larger group.

Distribute the Feedback Sheet (see page 79) to each participant and provide a few minutes for them to give their written comments prior to closing. One method of doing this is to facilitate a large group discussion in which you ask for verbal feedback. Participants then have the opportunity to provide both public and private feedback.

Appendices

Appendix 1: Interviewing questions

Appendix 2: Pattern recognition prompts

Appendix 3: Completed tools 1-3 for Scenario 2

Tool 1 – Current & Historical Record of Violence & Threats (Jack)

Tool 2 – Pathways to Violence: Pattern Description (Jack)

Tool 3 – Care Plan: Risk Management Components (Jack, inpatient)

Tool 3 – Care Plan: Risk Management Components (Jack, community)

Appendix 4: Completed tools 1-3 for Scenario 3

Tool 1 – Current & Historical Record of Violence & Threats (Pouli)

Tool 2 – Pathways to Violence: Pattern Description (Pouli)

Tool 3 – Care Plan: Risk Management Components (Pouli, developed for community treatment)

Appendix 5: Scenario 5 – Craig (forensic)

Completed tools 1-3 for Scenario 5

Tool 1 – Current & Historical Record of Violence & Threats (Craig)

Tool 2 – Pathways to Violence: Pattern Description (Craig)

Tool 3 – Care Plan: Risk Management Components (Craig)

Completed HCR-20 for Scenario 5 (Craig)

Appendix 6: HCR-20 – description

HCR-20 – Risk Assessment Scheme: Items

Appendix 7: FAQ's

Appendix 8: Trainer's delivery notes

Appendix 9: Audit tool for risk management care plan

Appendix 10: Useful websites

Appendix 11: References

Appendix 12 : Feedback form

Appendix 1: interviewing questions

Overview

1. There is no substitute for asking simple, direct questions in relation to risk.
2. As in any clinical interviewing situation, useful responses are more likely to be gained if attempts are made to engage the person at an emotional level relating to their main current concerns, anxieties or complaints. These can be considered gates to questions.
3. It is useful to become familiar with cascades of questions that tend to follow on naturally from the previous enquiry.

Current information (to weigh against historical information) relating to the persons mental state, behaviours and present situation can be organised into the following three categories.

4. A presenting violent or threatening event.
5. The person's mental state, situation and behaviours over the past six to eight weeks.
6. Current mental state.

Violent or threatening event

- Can you tell me in as much detail as possible, from start to finish, about what happened?
- Can you tell me what you were thinking and feeling as the situation developed?
- What did you intend to do?
- Did things work out as you wanted them to? (What happened that you did not want to happen? What else did you want to happen?)
- Did you plan any of this?
- What do you think caused the situation?
- Who should take responsibility for what happened?
- How do you feel now about what happened?

Past six to eight weeks

- What has been happening in your life in the past few weeks?
- Have there been any changes in your life circumstances (housing, employment, relationships, losses)?
- How did this change(s) make you feel?

- Have you had any other thoughts, feelings or body sensations that come up again and again (what are they like, how often)?
- Have you been angry or afraid of anybody over the past few weeks (who, why, where are they)?
- Have you had thoughts of harming anybody over the past few weeks? (Who?)
- How often have you been having these thoughts? (Playing on your mind?)
- How close have you been to acting on these violent thoughts in the past six to eight weeks?
- Have you been planning how you would act violently over the past six to eight weeks?

Current mental state

Fearfulness gate (victimisation gate)

- Do you have any concerns for your own safety?
- Do you feel frightened or worried about somebody hurting you?
- What do you need to do to protect yourself?
- Have you been victimised in any way?
- Do you think you might have to defend yourself?
- Have you taken any steps to defend yourself, such as getting a weapon?

Anger or sense of entitlement gate

- Are you angry at anyone?
- Who are you angry at (why)?
- What options have you got in dealing with the situation?
- Have you thought about hurting this person?
- Does anyone deserve to get hurt?

Thoughts–intent–plan cascade

- Are you thinking about hurting anyone?
- Do you intend to harm anyone?
- Have you made plans to harm anyone or defend yourself?

Questions to clarify aspects of persecutory delusional beliefs

- How have you been getting along with people?
- Is anybody against you?
- Is anybody trying to harm you?
- Have you identified any particular person or group who is trying to harm you?
- Have you harmed anybody in the past in a similar situation?
- How much of the time is this situation on your mind?
- Do you think the situation will sort itself out or do you think you will need to do something about it?
- Is the situation under control or do you feel you have lost control of the situation?

Level of intent (to be asked following any entrance)

- Do you have any other options to acting violently? (Do you have any alternative?)
- What do you think will happen if you act violently? (What will the consequences for you be?)
- Do you think you are capable of hurting the other person? (What are the risks for you?)
- Can you look after yourself if it comes to physical confrontation?
- Are you carrying a weapon around with you?
- What is stopping you from being violent?
- Are you able to control these thoughts about hurting?

Appendix 2: pattern recognition prompts

Patterns: risk behaviours

- Was the person involved in regular fighting or bullying as a child or adolescent?
- Approximately how many times has the person been violent as an adult?
- Approximately how many times have they made significant threats?
- What is their most serious violence?
- Have victims required medical attention for their injuries?
- What is their most recent violence?
- Is their violence typically sustained?
- Is there a premeditated or planning element to the violence?
- What stops their violence?
- Do they have particular skills or interest in fighting?
- What weapons have they used in the past?
- Has violence increased in frequency?
- Has violence increased in severity?
- Are there a number of different types of violence (e.g. different victim groups)?
- Is there any pattern in terms of the victims of violence?
- If the person is violent again, who would be the most likely victim(s)?

Patterns: situational aspects

- Are there any patterns in terms of the immediate triggers or precipitants for violence?
- What is the timeline to violence (does it come out of the blue or is there a build up of tension)?
- Is violence related to demands or expectations on behalf of the person?
- Is violent behaviour related to stressful situations (e.g. involving perceived threat, losses, demands, or change)?
- Is violent behaviour related to loss events or any threat of loss?
- Is violence associated with survival?

- Is violence associated with social isolation?
- Is violence associated with gang affiliation?
- Is violence related to other criminal activity (e.g. acquisitive offending to fund substance abuse)?
- Does violence occur in the context of alcohol or substance intoxication or withdrawal?
- Is violent behaviour related to discontinuation of medication and relapse of mental illness?
- Has violence been related to physical illness?
- Does the person have access to weapons now?

Patterns: internal aspects

- Is there any pattern in terms of the emotional state of the person, which leads them to violence (e.g. fearfulness, anger, a frustrated sense of entitlement, humiliation, self righteousness, jealousy)?
- At the time of acting violently, was the person aware of potential consequences?
- Is there a pattern of impulsive behaviour or emotional lability.
- Is there a significant history of violent behaviour prior to the onset of any mental illness?
- Does violence occur within the context of psychosis?
- Is there a direct relationship between violence and psychotic symptoms (e.g. persecutory delusions, delusions of control or passivity, command hallucinations, jealousy)?
- Is there an indirect relationship between violence and psychotic symptoms (i.e. no direct link but violence appears to be linked to non-specific effects of psychotic disturbance, such as disorganisation, disinhibition or low tolerance to frustration)?
- Does the person have any organic pathology that is relevant to the violent behaviour?
- Does violence appear to be related to acute confused states?
- Does violence appear to be related to abnormally elevated or depressed mood?
- Does the person have personality traits that are relevant to the violent behaviour?
- Does the person have any particular sensitivity to which they are likely to react violently?

- Does the person have values or beliefs that are relevant to the violent behaviour?
- Does the person have a trauma history that is relevant to the violent behaviour?
- Does the person have any particular fantasies or sexual arousal patterns linked to violent behaviour?
- Is there any evidence of sadistic behaviour?

Risk description

- What is the likelihood of the person acting in a violent manner?
- How imminent or immediate is the risk of violent behaviour?
- How often is the person likely to act violently?
- If they were to act violently, how serious would the violence be?
- Is the risk specific or general?
- How rapidly does the risk escalate?
- What are the main pathways to violence for this person?

Appendix 3: completed tools 1 to 3 for scenario 2

Tool 1: Current & Historical Record of Violence & Threats

Name: Jack DoB: NHI Number:

Date	Risk Behaviours	Internal factors	Situational factors	Outcome
Date of incident	<ul style="list-style-type: none"> Describe risk behaviour e.g. violence, threat Victim(s) & injuries? Weapon use? What stopped the violent behaviour? 	<ul style="list-style-type: none"> What did the person think/feel/perceive? What did others notice? Early warning signs? What was the timeline to violence? Coping strategies 	<ul style="list-style-type: none"> e.g. Context or immediate trigger? e.g. Serious stress? e.g. Alcohol or drug use? e.g. Discontinuation of medication? e.g. Social situation? 	<ul style="list-style-type: none"> Clinical consequences? Legal consequences? Any change in social relationships? Any change to care plan?
Current	<p>Presenting incident?</p> <ul style="list-style-type: none"> Two physical assaults on girlfriend in the past two weeks driven by jealous delusions Ongoing monitoring of her whereabouts Possible intent towards a policeman 	<p>Current mental state</p> <ul style="list-style-type: none"> Persecutory delusions Auditory hallucinations re specific policeman Jealous delusions re girlfriend Arousal Poor sleep 	<p>Current situation</p> <ul style="list-style-type: none"> Daily amphetamine use Regular marijuana and diazepam use Access to weapons (firearms) Criminal subculture with high tolerance to violence and suspicion of authorities 	<ul style="list-style-type: none"> Currently under probation
Recent (last 6-8 weeks)	<p>Preparation, weapons, near misses</p>	<p>Pre-occupations, planning, targets, coping</p>	<p>Recent change, stress</p>	
	Past convictions for rape, burglary and male assaults female			Convicted and served time in prison

Completed by: S Jones / Dr Smith. Position: Staff nurse / Inpatient Psychiatrist Date: Next Review: On discharge

Tool 2: Pathways to Violence: Pattern Description

Name: Jack

NHI: Scenario 2

DoB: 32

This person is at risk of acting in the following way

(include acts; weapons; likely victims):

Currently Jack is at high risk of further physical assaults to his girlfriend and at potential risk of physically assaulting someone from the police – including the identified officer or any male that he may identify as sleeping with his girlfriend. There is a serious risk of using firearms as he has access to a range of weapons and discharged a firearm in unknown circumstances. There is a past history of sexual assault on a woman.

They are more likely to act this way when they experience:

(include subjective symptoms; objective signs; speed of relapse; seriousness)

1. Current untreated delusions and hallucinations.
2. Evidence that is interpreted as substantiating delusions.
3. Confrontation.
4.

They are more likely to act this way in the following circumstances or situations:

(e.g. interpersonal stressors; social dynamics; medication non-adherence; substance abuse; access to weapons; access to potential victims; likelihood and imminence of risk)

1. Ongoing amphetamine use.
2. Ongoing use of other illicit substances.
3. Conflict within criminal subculture.
4.

The following act as protective factors:

1. Finds experiences distressing and wants help to resolve them.
2. Supportive girlfriend and respect within the gang.
3. Occupational and social skills as evidenced by high-ranking position.
4.

Completed by: S Jones / Dr Smith

Date: On admission

Position: Staff nurse / Psychiatrist

Next review: On discharge

Tool 3: Care Plan: Risk Management Components

Name: Jack

NHI: Scenario 2 (Inpatient)

DoB: 32

SHARED INFORMATION / CONTACT LIST	
Individuals and group (contact details)	Information to be shared and its purpose
1. Girlfriend	Education re mental illness and clinical pathways
2. Father	Education re mental illness and clinical pathways
3. Probation officer	Information re mental illness and clinical pathways
4. Community Team	Discharge planning
Consumer agrees with the above information sharing Yes / no	If no, state overriding concerns:

MONITORING: EARLY WARNING SIGNS & SITUATIONS
1. Monitor sleep and aim for restoration of sleep over admission
2. Monitor for increasing irritability and agitation and aim to reduce this
3. Monitor intensity and frequency of hallucinations – ask around intent towards policeman
4. Discuss feelings towards girlfriend regarding delusions of jealousy
5. Monitor interactions with staff and patients and intervene early if patterns of verbal altercation or any signs of conflict

SPECIFIC STRATEGIES TO REDUCE RISK		
Strategy (General & specific)	Who?	When?
1. Ensure Jack is admitted to hospital for safety and containment whilst symptoms are treated. (Use Mental Health Act if necessary – involve whanau, explain risks.)	Community doctor and inpatient team	At the time of clinic assessment
2. Active treatment of arousal and psychotic symptoms. (Chart regular risperidone and lorazepam + PRN lorazepam for sleep or agitation.)	Psychiatrist / nursing staff	On admission and review at each handover
3. Liaison with probation officer. (Find conditions and term. Clarify with Jack boundaries of communication. Explain role of antipsychotics and discuss times of risk.)	Nurse / psychiatrist	Liaise PRN
4. Meeting with whanau and support people. (Invite to meeting, explain presenting symptoms and need for treatment and how this is being followed. Discuss the effect of amphetamines on Jack's symptoms. The sister who receives treatment from services may be part of this meeting; involvement of cultural services to facilitate engagement.)	Team	>1 meeting may be needed
5. Discharge Planning. (Invite all parties to a meeting when Jack is still in hospital. Discuss mental health support for Jack on release.)	Jack, whanau, inpatient and, community teams	When Jack is well enough to participate

Completed by: S Jones / Dr Smith

Date:

Position: S/N + Psychiatrist

Review: Update during admission, review on discharge

Plan was reviewed by.....

Date:.....

Tool 3: Care Plan: Risk Management Components

Name: Jack

NHI: Scenario 2 (Community)

DoB: 32

SHARED INFORMATION / CONTACT LIST	
Individuals and group (contact details)	Information to be shared and its purpose
1. Girlfriend	Education re EWS pertaining to her, what she can do. Purpose: protection
2. Father	Education re observable EWS and substance use. Purpose: monitoring and referral to MH
3. Probation officer	Information re specific ideation pertaining to being monitored. Purpose: protection and liaison with MH
Consumer agrees with the above information sharing	If no, state overriding concerns:
Yes / no	

MONITORING: EARLY WARNING SIGNS & SITUATIONS
1. More than one night of no sleep
2. Starting to feel suspicious or irritable
3. Any onset of voices or unclear mumbling or suspicious sounds
4. Starting to feel suspicious of whether girlfriend cheating

SPECIFIC STRATEGIES TO REDUCE RISK		
Strategy (General & specific)	Who?	When?
1. Ensure supervision and adherence to risperidone. (When symptom-free self-dispenses; when symptomatic, team or whanau medicates)	Nurse / Psychiatrist	Weekly if well or daily if signs of relapse
2. Aim for reduction or abstinence of amphetamine. (Prioritise over THC and other. Discuss with Jack and whanau effects and risks of amphetamine use, use MI strategies. Explore his role within gang and how it relates to amphetamines).	Nurse Psychiatrist CSW	Every contact
3. Liaison with probation officer – find conditions and term. (Clarify with Jack boundaries of communication. Communicate role of antipsychotics and discuss times of risk.)	Nurse / Psychiatrist	Liaise PRN
4. Therapeutic relationship with Jack, girlfriend and whanau. (Supportive relationship that assists with problem solving. Frequent regular contact and active tracking when needed.)	All team	See minimum of weekly and respond PRN
5. Staff and other safety concerns. (Clarify with Jack which places the team are able to visit; whether there are guns on site; whether other gang members know about mental health service involvement; whether there are key people the team need to meet. Clarify in advance how Jack would be assisted to hospital if he was to have a major relapse. If the police are not an option, which whanau or other people could be called on.)	Psychiatrist	Review with Jack and all relevant others regularly

Completed by: H Grey

Date:

Position: Community Nurse

Review: Three months

Plan was reviewed by.....

Date:.....

Appendix 4: completed tools 1 to 3 for scenario 3

Tool 1: Current & Historical Record of Violence & Threats

Name: Pouli

DoB:

NHI Number:

Date	Risk Behaviours	Internal factors	Situational factors	Outcome
Date of incident	<ul style="list-style-type: none"> Describe risk behaviour e.g. violence, threat Victim(s) & injuries? Weapon use? What stopped the violent behaviour? 	<ul style="list-style-type: none"> What did the person think/feel/perceive? What did others notice? Early warning signs? What was the timeline to violence? Coping strategies 	<ul style="list-style-type: none"> e.g. Context or immediate trigger? e.g. Serious stress? e.g. Alcohol or drug use? e.g. Discontinuation of medication? e.g. Social situation? 	<ul style="list-style-type: none"> Clinical consequences? Legal consequences? Any change in social relationships? Any change to care plan?
Current	<ul style="list-style-type: none"> Presenting incident? Follow-up post-discharge 	<ul style="list-style-type: none"> Current mental state Withdrawn Query poor insight Uncertain whether active psychotic symptoms remain, difficult to access 	<ul style="list-style-type: none"> Current situation Moved from sister's to brother's place Not working Prescribed antipsychotic medication ?effect, ?adherence 	<ul style="list-style-type: none"> Currently under probation
Recent (last 6-8 weeks)	<ul style="list-style-type: none"> Preparation, weapons, near misses Near miss – chased sister with machete Action led to hospitalisation 	<ul style="list-style-type: none"> Pre-occupations, planning, targets, coping Grandiose delusions Sexual delusions Auditory hallucinations from Holy Spirit 	<ul style="list-style-type: none"> Recent change, stress Stopped working 	<ul style="list-style-type: none"> Acute admission to mental health unit
	No known past history			

Completed by: S Jones / Dr Smith. Position: Staff nurse / Inpatient Psychiatrist Date: Next Review: On discharge

Tool 2: Pathways to Violence: Pattern Description

Name: Pouli

NHI:

DoB:

This person is at risk of acting in the following way

(include acts; weapons; likely victims):

Pouli has a risk of physically assaulting people who confront his delusional system when he is actively psychotic. He has threatened his sister with a machete. There is an unknown possibility of sexual risk related to the nature of his delusional system, which has not been fully explored.

They are more likely to act this way when they experience:

(include subjective symptoms; objective signs; speed of relapse; seriousness)

1. Grandiose delusions.
2. Hallucinations of a religious nature.
3.

They are more likely to act this way in the following circumstances or situations:

(e.g. interpersonal stressors; social dynamics; medication non-adherence; substance abuse; access to weapons; access to potential victims; likelihood and imminence of risk)

1. Confrontation of his delusional system.
2. When there is a lack of antipsychotic treatment and mental health engagement.
3.

The following act as protective factors:

1. Antipsychotic medication.
2. Support of family regarding treatment of illness.
3. Support of church.
4. No history of alcohol and drug use.
5.

Completed by:.....

Date: November 2005

Position:

Next review: Weekly

Tool 3: Care Plan: Risk Management Components

Name: Pouli

NHI: Developed for Community Treatment

DoB:

SHARED INFORMATION / CONTACT LIST	
Individuals and group (contact details)	Information to be shared and its purpose
1. Brother	Education re mental illness
2. Sister	Education re mental illness
3. Church contact	Education and liaison re mental illness
Consumer agrees with the above information sharing Yes / no	If no, state overriding concerns:

MONITORING: EARLY WARNING SIGNS & SITUATIONS
1. Increasing preoccupation and withdrawal from family
2. Onset of voices
3. Discussing beliefs regarding special role as a eunuch or sexual protector

SPECIFIC STRATEGIES TO REDUCE RISK		
Strategy (General & specific)	Who?	When?
1. Establish a therapeutic relationship with Pouli and his family. (Provide information on symptoms and treatment offer practical support and empathic style. Acknowledge Pouli and family distress at what has happened and help resolve tensions within the family).	Community nurse, cultural worker and psychiatrist	Weekly contact (offer home and clinic meetings; combinations of individual and family meetings. Ensure some individual assessment time)
2. Ensure resolution of delusions and hallucinations through antipsychotic treatment. (Review mental state. Ensure adherence either through self-dispensing or with family or clinical services support. Optimise dose, monitor for side-effects and response. Olanzapine may need to be increased.)	Nurse and psychiatrist	Nurse review regularly – starting weekly and reducing frequency as improving
3. Family support and education. (Develop a shared understanding of issues, discuss explanatory models. Discuss how to access mental health services.)	Team with appropriate cultural input	Establish time frames with family
4. Rehabilitation issues. (Work with Pouli to help increase confidence and functioning. Listen to his goals and help support him toward them, e.g. work.)	Team? refer also to NGO services	As part of every interaction
5. Spiritual. (To advise whether meeting with minister helpful.)	Cultural services	

Completed by: K Parker

Date:

Position: Community Key Worker

Review: Three months

Plan was reviewed by.....

Date:.....

Appendix 5: scenario 5 – Craig (forensic)

Craig is aged 35 years, has one child whom he does not see, has no current stable relationship, and is currently a resident in a forensic rehabilitation ward but is shortly seeking to move to supported accommodation. He is not employed, although he does engage in workshop activities.

He is the middle of four children, from a disturbed family background. His parents' relationship was troubled by violence, with evidence of physical abuse of the children and to some degree emotional neglect. His parents separated when he was 12 and he was cared for by both his mother and his maternal grandmother.

Some behavioural difficulties were noted as a child. He had some conduct difficulties at school, which resulted in getting into fights. Truancy emerged as a problem at about ten years of age and he was suspended from school for smoking at 13. Truancy was an increasing problem when he was 14 and 15, with the result of his leaving school at the age of 15 with no formal qualifications. He had an onset of substance abuse, notably solvents from the age of about 12 and alcohol and cannabis from about 14 years of age.

He first came into contact with the law as a 16 year old and has convictions for theft, wilful damage, common assault, assault with intent to commit sexual violation and assault with intent. He does not have a history of weapon use. The most serious physical injury suffered by his victims required outpatient A&E attendance.

He does not have a stable work record. He worked in a number of semi-skilled factory and labouring roles but most recently has been involved in stable employment in a sheltered workshop as a patient representative, as well as completing his occupational tasks. He has had one long term, de facto partner of five years, with whom he has one child. The relationship ended because of violence and illness issues. He has no contact with her now.

He has a history of mental illness dating from 18 years of age, when he reports the onset of auditory hallucinations. He did not however receive any mental health treatment until his early 20s and had a series of admissions to hospital or care within the prison context. He showed a partial response to depot neuroleptics and was in limited contact with mental health services. The current episode of care commenced six years ago. He was charged with assault with intent on a person who he met and was only loosely acquainted with. He assaulted the victim manually, which resulted in cuts and bruising dealt with by A&E services. He complained of persecutory delusions and command hallucinations to harm this person, to prevent being attacked by him. This occurred at a time when Craig was non-compliant with medication, was abusing cannabis and was not in receipt of mental health follow-up. He was found criminally responsible for the assault, but received a section 118 disposition.

During the early periods of his admission, he was noted to be grandiose, troubled by persecutory ideas and auditory hallucinations. In addition, he seemed to employ stand-over tactics with other patients, extorting cigarettes from them and appeared to use his size and criminal past (involvement with gangs) as a means of maintaining a position of power and influence within the milieu. After three years of hospitalisation and despite initial resistance to acknowledgement that he had

an illness, Craig's attitude progressively softened. Furthermore, his use of stand-over tactics and negative approaches to others within the ward lessened to the point where he shifted in his behaviour from antisocial and oppositional stances to active engagement, wish for support from services and supportiveness of other patients within the ward. He was eventually discharged to a community setting where he lived successfully for two and a half years. There was one incident within that time of feeling unsupported and not listened to by staff. After leaving this facility Craig committed an act of wilful damage and was convicted of this charge. As a result, he returned to that residence, worked through the relationship difficulties and continued to stay there until the current (two month) admission. There was one further incident where he was accused of sexual abuse of another resident. He denied this and no convincing evidence was found.

He did however after a change in medication, suffer a relapse of psychotic symptoms despite compliance with medication. This was a result, in part, of surreptitious abuse of cannabis.

Having returned to hospital and abstained from cannabis and with an increase of medication, he now suffers low grade auditory hallucinations only and no apparent persecutory ideation. There has been no evidence of disturbed, violent or threatening behaviour towards others. He is less withdrawn and more functional than he was when first readmitted. He now wishes to return to the facility in which he relapsed, stating that he will abstain from drugs and can regain his prior level of functioning. He does report difficulties in his relationship with one supervising staff member there and ongoing stress from his other family members. He wishes to return to a sheltered workshop.

Diagnosis

Axis I Schizophrenia

Axis II Antisocial personality disorder. Psychopathy checklist score of 20.

Axis III Non-insulin dependent diabetes mellitus.

1. Use the HCR-20 framework to develop a violence risk assessment for Craig.

2. What information of practical value is gained by this process?

- The information helps to put into context the current risk and assists in identifying the factors in his mental state and current circumstances that can help to reduce the risk of further violence.
- It adds to the standard risk formulation by emphasising the developmental factors associated with violence in his case, but many of the illness-related variables were already emphasised by the standard risk formulation.

Tool 1: Current & Historical Record of Violence & Threats

Name: Craig

DoB:

NHI Number:

Date	Violent or threatening behaviour	Internal	Situational	Outcome
Date of incident	<ul style="list-style-type: none"> Describe behaviour Victim(s) and injuries? Weapon use? What stopped the violent behaviour? 	<ul style="list-style-type: none"> What did the person think, feel or perceive? What did others notice? Early warning signs? What was the timeline to violence? Coping strategies 	<ul style="list-style-type: none"> e.g. Context or immediate trigger? e.g. Serious stress? e.g. Alcohol or drug use? e.g. Discontinuation of medication? e.g. Social situation? 	<ul style="list-style-type: none"> Clinical consequences? Legal consequences? Any change in social relationships? Any change to care plan?
23/3/90	Involved in a fight with another patron at a bar. Manual assault with bruising to the victim. Fight was broken up by hotel bouncer.	Does not recall what the fight was about, may have been over a woman, but states the other man threatened him. Claims he was not unwell at the time.	Public bar, alcohol involved.	Convicted and served three month imprisonment.
24/2/93	Assault with intent to commit sexual violation. Was part of a group of three men who assaulted a woman in a party situation, one of whom sexually assaulted her.	Little information. Craig is reticent to discuss it, but states he was part of a group and should not have done it.	Occurred at a party, and had been drinking heavily. No major stressors.	Plead guilty and served a two-and-a-half year sentence. Followed up by the prison mental health team during sentence.
7/6/98	Physically assaulted a man of similar age who was the friend of a flatmate. Used fists and kicked victim once. Resulted in bruising and cuts. Stopped when friend intervened.	Craig complained of persecutory feelings that the victim was looking at him strangely, and voices told him to stop the victim before the threats got worse. Reports feeling threatened and frightened.	Craig had not been engaged with services, and was non-compliant with antipsychotic medication. He had been using cannabis and alcohol sporadically. Living with other drug users in an unstable context, having separated from his partner six months previously.	Arrested and remanded in custody, where found to be mentally unwell. Court report noted presence of active mental illness, but not meeting criteria for the insanity standard. Convicted but committed to hospital.
Recent (past 6-8 weeks)	Preparation, weapons, near misses Nil	Preoccupations, planning, targets, coping Nil. Coping well with supports, and does not report current threatening or violent feelings.	Recent change, stress Recently readmitted because of stress and abuse of cannabis leading to relapse.	
Current	Presenting incident? Property damage associated with stress, substance misuse and relapse of symptoms.	Current mental state Low-grade auditory hallucinations, but otherwise calm, engaged and insightful.	Current situation Wishes to return to the community following period of respite readmission. Some stressors persist.	

Completed by: Dr A Smith

Position: Forensic Psychiatrist, Mason Clinic

Date: 30/8/04

Next Review: Three months

Tool 2: Pathways to Violence: Pattern Description

Name: Craig

NHI:

DoB:

This person is at risk of acting in the following way

(include acts; weapons; likely victims):

Violently assaulting someone in his immediate social environment in a sustained way. Manually, with risk of significant injury but without weapon use. Uncertain risk of sexual assault.

They are more likely to act this way when they experience:

(include subjective symptoms; objective signs; speed of relapse; seriousness)

1. Persecutory delusions and command hallucinations.
2. Fearfulness.

They are more likely to act this way in the following circumstances or situations:

(e.g. interpersonal stressors; social dynamics; medication non-adherence; substance abuse; access to weapons; access to potential victims; likelihood and imminence of risk)

1. Non-engagement with mental health services.
2. Non-compliant with medication.
3. Abusing substances.
4. In unstable, antisocial environments.
5. Stressful interpersonal contexts.

The following act as protective factors:

1. Stable and supportive environment around him.
2. Work stability.

Completed by: Dr A Smith

Date: 1/9/04

Position: MOSS, Mason Clinic.

Next review: Three months.

Tool 3: Care Plan: Risk Management Components

Name: Craig

NHI:

DoB:

SHARED INFORMATION / CONTACT LIST	
Individuals and group (contact details)	Information to be shared and its purpose
1. Forensic community team	Full clinical summary and handover
2. Care level 3 accommodation provider	Relevant clinical summary including EWS and contact details for community team
3. Sister in Onehunga	Education re mental illness and clinical pathways
Consumer agrees with the above information sharing Yes / no	If no, state overriding concerns:

MONITORING: EARLY WARNING SIGNS & SITUATIONS
1. Feeling stressed
2. Withdrawing from others and communicating less
3. Voices worsening and becoming distrustful of others
4. Urge to use drugs

SPECIFIC STRATEGIES TO REDUCE RISK		
Strategy (General & specific)	Who?	When?
1. Talk regularly with key worker re stress and temptation to use drugs. (Home visits)	Key worker	Twice per week
2. Talk regularly with staff at home. (Talks)	Supervisor	Daily
3. Remain on medication. (Check blister packs)	Self-medication	Weekly
4. Regular drug screen. (During visits)	Key worker	Weekly
5. Support in maintaining positive social networks. (Work and family contact)	CSW	Three times per week

Completed by: Dr A Smith

Date: 1/9/04

Position: MOSS Mason Clinic

Review: Three months

Plan was reviewed by.....

Date:.....

Completed HCR-20 for scenario 5 (Craig)

FILE LOCATION: Management / Crisis

FORM GUIDELINES					
Sources of Information:	A review of KEY incidents, observations or diagnostic opinions relevant to the criteria for each item being rated. HCR-20 Assessing Risk for Violence – Version 2				
Completion by	<table border="1"> <tr> <td>1st Completed:</td> <td>Prior to completion of 1st Comp. Clinical Summary</td> </tr> <tr> <td>Reviewed</td> <td>Prior to In-Depth Health Care Planning</td> </tr> </table>	1st Completed:	Prior to completion of 1st Comp. Clinical Summary	Reviewed	Prior to In-Depth Health Care Planning
1st Completed:	Prior to completion of 1st Comp. Clinical Summary				
Reviewed	Prior to In-Depth Health Care Planning				
Using the Information:	Risk Assessment and Risk Formulation, Comprehensive Clinical Summary, Health Care planning. Enables thorough consideration of information used for ratings, and promotes consistency.				

HISTORICAL ITEMS:

H 1 – Previous violence	Code (0, 1, or 2)	2
Fighting at school lead on to convictions for common assault, assault with intent to commit sexual violation and assault with intent to injury. He does not have a history of weapon use and no victim has received injuries that required inpatient care.		
H 2 – Young age at first violent incident	Code (0, 1, or 2)	2
His first conviction for violence was at 18 years of age, but had a history of fights when younger.		

TITLE: HCR-20 Coding Worksheet
 FUNCTION: Risk Assessment Review
 RISK MANAGEMENT ITEMS:

R 1 – Plans lack feasibility	Code (0, 1, or 2)	0
Plan to return to his supported community accommodation and work are both reasonable although there are some persisting stresses there.		
R 2 – Exposure to destabilises	Code (0, 1, or 2)	1
There are drugs of abuse available to him in his accommodation and from other community contacts.		
R 3 – Lack of personal support	Code (0, 1, or 2)	1
There is good support from the community mental health team and from most staff at his supported home, but lack of support from family and one other staff member.		
R 4 – Non-compliance with remediation attempts	Code (0, 1, or 2)	1
He is well-engaged with his treatment plan and happy to engage with therapeutic and rehabilitative plans.		
R 5 – Stress	Code (0, 1, or 2)	1
Some stressors are present, such as the staff member he does not get on with and family tension, which indicates a moderate probability of stress will be experienced.		
Risk Management Total:		3 /10
HCR - 20 Total:		/40
Final Risk Judgement	Low	High
	<input type="radio"/> Low	<input type="radio"/> Moderate <input type="radio"/> High
Responsible Clinician		
<input type="radio"/> Other Name Signature	

Completed HCR-20 for scenario 5 (Craig) continued

TITLE: HCR-20 Coding Worksheet
FUNCTION: Risk Assessment Review
RISK MANAGEMENT ITEMS:

H 3 – Relationship instability	Code (0, 1, or 2)	1
He has had few long-term stable relationships but has managed one relationship of five years duration, which ended because of problems with his illness and violence.		
H 4 – Employment problems	Code (0, 1, or 2)	1
He has a history of an unstable work pattern, but has sought and remained in work. In recent times he has shown occupational stability in the supervised work context.		
H 5 – Substance abuse	Code (0, 1, or 2)	2
Early onset of solvent, cannabis and alcohol use in his early teenage years.		
H 6 – Major mental illness	Code (0, 1, or 2)	2
Diagnosis of schizophrenia.		
H 7 – Psychopathy	Code (0, 1, or 2)	1
PCLR score of 20.		
H 8 – Early maladjustment	Code (0, 1, or 2)	2
Disturbed family upbringing with behavioural problems of conduct, truancy and fighting from prior to teenage years, and suspension from school.		
H 9 – Personality disorder	Code (0, 1, or 2)	2
Meets criteria for antisocial personality disorder.		
H 10 – Prior supervision failure	Code (0, 1, or 2)	1
No major failures on this category, but minor reoffending has occurred.		
Historical Item Total:		16 /20

FILE LOCATION: Management / Crisis

CLINICAL ITEMS:

C 1 – Lack of insight	Code (0, 1, or 2)	0
He understands he has a mental illness and needs to take medication with which he complies, but does find it hard to communicate about EWS.		
C 2 – Negative attitudes	Code (0, 1, or 2)	1
Whilst he has a very clear background of negative, antisocial attitudes, he has let them go over the past two to three years and his behavioural pattern has generally been pro-social. The one incident of being accused of sexual assault of another resident was not proven, and was not in keeping with other observed behaviour. This makes scoring this item difficult. It could be argued that a score of 1 should be given.		
C 3 – Active symptoms of major mental illness	Code (0, 1, or 2)	1
Low-grade auditory hallucinations, with no other active symptoms apparent.		
C 4 – Impulsivity	Code (0, 1, or 2)	1
No major evidence for this item, but some suggestion of problems of impulse control or affective instability. He did cause property damage after the long culmination of stress in his home, but is generally stable in his behaviour.		
C 5 – Unresponsive to treatment	Code (0, 1, or 2)	0
Craig shows good engagement with services and compliance with treatment plans. His recent relapse was related to other factors, such as sensitivity to stress and relapse of substance use, rather than rejection of treatment.		
Clinical Items Total:		16 /20

Appendix 6: HCR-20 – description

1. The HCR-20 was developed in Canada by Webster, Douglas, Eaves and Hart, of the Simon Fraser University and the British Columbia Forensic Psychiatry Service Commission (Webster, Douglas, Eaves, & Hart, 1997).
2. It was designed to draw on evidence from the literature of factors that are associated with violence amongst people with mental illness, and to do so in a manner that would guide clinical intervention.
3. When first introduced in 1995, it generated considerable interest and was revised to its current form, which was released in 1997. It has been tested in forensic and general mental health settings and found to be as good a predictive tool as any that is available in the world literature. It is in wide use worldwide, including in North America, Europe and Australasia.
4. HCR-20 groups risk markers into three conceptually linked scales:
 - (a) **H**istorical (past) 10 factors
 - (b) **C**linical (present) 5 factors
 - (c) **R**isk (future context) 5 factors
5. Each factor is scored 0, 1 or 2. The individual factors are listed on the following page.
6. Scores are totalled in subsections and in total, but risk is then conceptualised as low, medium or high in a particular context. In other words, it is not the score on its own that counts, but how the clinician makes sense of these risk factors or other risk factors relevant to this person at this time that is finally recorded.
7. Thus, the HCR-20 acts as a structure to guide the risk formulation that we have outlined in this programme, but does so in greater detail. Also, the C and R scores alter dynamically during treatment and rehabilitation.

HCR-20 risk assessment scheme – items

Sub-Scales

Factors

Historical scale

H1	Previous violence
H2	Young age at first violent incident
H3	Relationship instability
H4	Employment problems
H5	Substance use problems
H6	Major mental illness
H7	Psychopathy
H8	Early maladjustment
H9	Personality disorder
H10	Prior supervision failure

Clinical scale

C1	Lack of insight
C2	Negative attitudes
C3	Active symptoms of major mental illness
C4	Impulsivity
C5	Unresponsive to treatment

Risk management scale

R1	Plans lack feasibility
R2	Exposure to destabilisers
R3	Lack of personal support
R4	Non-compliance with remediation attempts
R5	Stress

Notes

1. Adapted with permission from Webster et al. (1997)
2. The HCR-20 **should only be scored** with reference to the scoring manual and after attendance at an HCR-20 training programme.

Appendix 7: FAQs

1. If I document risk and something happens, will I be more liable?

Failure to address risk is worse than addressing it with poor outcomes. However, identified risks should always be addressed via a risk management plan. It is impossible to eliminate risk and, therefore, the focus should be on reducing it insofar as this is possible and appropriate. Even with good care and risk management, adverse outcomes can occur. Inquiries or reviews of unwanted outcomes are likely to be more critical of services or individuals who fail to attempt to implement risk assessment and management processes than those who make genuine attempts to do so.

2. If I know I can't do anything about the risk, why do a risk assessment anyway?

Making decisions about risk management before doing a risk assessment is putting the cart before the horse. The decision if and how the risk can be managed can only be made after a careful and comprehensive risk assessment has been conducted. Even if the risk cannot be entirely satisfactorily managed, a competent risk assessment may identify aspects of the risk that can be moderated in some way. For example, it may be that the risk assessment process identifies potential victims who could be protected by appropriate sharing. Also, risks that cannot be managed clinically may be dealt with at an organisational level, so that clinicians are not inappropriately held accountable.

3. Will I increase the risk of violence by asking questions about violent behaviour?

There is no evidence that asking consumers questions about violent intent increases risk of actual violent behaviour. Indeed, there is some indication that enquiring about violent thoughts can have a risk-lowering effect in some contexts. However, minimising consumers' concerns about violent thoughts may, in some situations, actually increase their risk for violence as the consumers may feel invalidated by not having their concern heard or understood.

4. Isn't it stigmatising for people with mental illness if we label them with statements about risk?

It would be more stigmatising for people with mental illness to act violently when effective risk management interventions could have prevented this. The emphasis of risk assessment is not on labelling. Rather, it should be on the development of a shared understanding of the consumer's pathways to violence and the related pathways to safety. Balanced risk assessment processes take into account protective factors and resilience. Furthermore, to avoid the labelling trap, it is critical that risk assessment and management occur within the context of a therapeutic relationship. The whole process is geared to reducing difficulties and promoting recovery.

5. Do we always have to do a full risk assessment or can we screen?

The extent and depth of risk assessment processes will obviously vary across mental health settings. Different organisations and systems will have different thresholds and expectations for risk assessment and management. Some services, for example forensic and intensive care settings, need to focus on risk assessment and management more than other settings. However, while organisational characteristics and policies should provide a framework for risk assessment and management the decision to conduct a full risk assessment also involves clinical judgement. It is important to understand that risk assessment is, among other things, an important component of care plans and should always be considered in the course of clinical work.

6. Does the quality of the relationship with the consumer influence the risk assessment process?

As emphasised in the workbook, the therapeutic relationship is central to risk assessment and management processes. Engagement with the consumer underpins all elements of effective clinical management. Sometimes, aspects of a person's mental illness may make development of a therapeutic relationship difficult for a period of time. However, even when there is a fundamental disagreement about clinical interventions, efforts must be made to engage with the consumer in a respectful manner.

7. How often should a risk assessment be done?

Depending upon the service, time frames for the reassessment of risk may vary. However, there are certain obvious junctures to undertake risk assessment tasks, including at the time of admission to inpatient settings and at the time of periodic case reviews (most services have policies that require case reviews to be held at 3 or 6 monthly intervals, as a minimum). Other clinically sensible opportunities for a reassessment of risk occur at times of deterioration in mental state, at times of increased stress and following violent incidents. Clinical judgement is required in those situations.

It is important to understand that, above all, risk assessment represents a way of thinking concerned with providing a foundation of safety for all concerned. It is the basis upon which recovery can be most effectively facilitated. Risk assessment is far more than a defensive completion of risk assessment forms. It is an integral part of the interactions between consumer and mental health practitioner and an aspect of continual clinical observation and judgement.

8. Who is responsible for ensuring that risk assessments are done?

Organisational policies should clearly assign responsibilities. It is recommended that risk assessment and management processes are carried out within the context of a multidisciplinary team and that different team members are assigned different tasks within an overall risk assessment process. Often overall responsibility for clinical decisions around the issue of risk management resides, as the name implies, with the responsible clinician. However, recent inquiries have demonstrated that there is now an expectation that everyone employed within mental health settings has an awareness around issues of risk, and each practitioner must be aware of their professional responsibilities and expectations.

9. How can these tools be relevant to my particular culture?

The approach presented in this workbook provides a generic framework for understanding pathways to violence. It is openly acknowledged that the specific details of people's individual belief systems and circumstances must be taken into account. In this respect, cultural aspects are one aspect of the overall process of thinking about risk assessment, albeit a very important, one. Other mediators, such as age and gender must also be considered. The key is that the risk assessment and management process must be individualised as is the overall care plan. It is tailored to the needs and requirements of the consumer, which implicitly includes cultural components.

10. What do I do if I discover that other people are at risk?

Although the exact wording and conceptualisation may vary across professions, there is an expectation that there is a duty to protect other individuals who are believed to be at risk of serious harm. This may, in some circumstances, involve breaching confidentiality. However, even in these circumstances, appropriate consideration of the issues described in the Privacy Act 1993 and the Health Information Privacy Code 1993 should be taken into account.

Appendix 8: trainer's delivery notes

1. Learning styles

The facilitation of these workshops should be based on adult learning principles. This approach to education espouses that both facilitator and learner bring life skills and experiences to the learning situation that enrich the process of learning. Furthermore, learning styles are unique to the individual, often reflective of the socio-cultural environment to which the individual belongs. Some people learn best through listening, some by watching and some by active involvement. The approach to learning must accommodate the variety of styles evident in the learner(s). Education sessions should be developed that accommodate multiple learning styles, which combine such approaches as didactic lecture, discussion, group learning, visual prompts and role play. Such developments will require a thorough assessment of the learning styles of those involved.

With different learning styles in mind, try to use the range of teaching aids available to you:

- whiteboard or flip chart
- PowerPoint presentation
- large group discussion
- small group work
- completed tools
- one-page overview
- role plays and clinical examples.

2. Context–overview–specifics

It is important that the participants are oriented as to when they are dealing with the overview (i.e. main learning points), and when they are dealing with specifics. One of the most effective ways of transferring information is to provide an overview of the task at hand prior to entering into discussion of specific detail. Often differences of opinion can have greater impact than they need to because a sense of perspective is lost and, in reality, participants are dealing with specific detail when, in fact, they agree with the larger principles. The concept of chunking up to establish agreement on the overview arises from this process. Repeated orientation of the participants helps reinforce the organisation of the information and the skills you are passing on during the workshop.

Throughout this process, it is essential that the examples you give provide a context for the participants. This is mostly done for you with the use of scenarios, which represent imaginary people composed of a combination of real life scenarios.

3. Skill acquisition

The workshop supports a skill acquisition approach to learning. This is made clear in the opening session when you explain that the two major determinants of skill acquisition are repetition, and specificity and structure. One method of achieving the goals and objectives of the workshop is to stay true to the skill acquisition approach to learning. Use natural breaks (e.g. just prior to breaks) and on return from breaks to ask different individuals or the group to repeat the main learning points (e.g. you can ask questions designed to elicit the main points), for example, how many stages in risk assessment are there? Or, what is the main task at the second stage of risk assessment? If you repeat the main learning points enough in active ways (e.g. asking different participants the answers rather than providing them or reciting them yourself; asking them to draw the model at various stages of the day on blank sheets of paper), you should have little doubt that by the end of the workshop the goals and objectives of the course will be met.

Appendix 9: audit tool for risk management care plan

This tool is designed to be used following implementation of the Violence Risk Assessment and Management for Mental Health Services Programme commissioned by the Ministry of Health. It allows each step of risk assessment to be evaluated. The tool can be used to audit individual care plans or summated as an average score (between 0 and 2) for each component.

Scoring notes

This tool has three scores to be given for each component.

- 0 – no or very little evidence that this task has been attempted.
- 1 – partial completion or some significant attempt to complete the task..
- 2 – substantial or full task completion.

Audit Tool: Risk Assessment and Management

Component	Specific Task	Score (0, 1, 2)
1. Information Gathering	Sources of information sought and identified	<input type="checkbox"/>
	Past violent or threatening events described (nature of event, circumstances, mental state, outcome)	<input type="checkbox"/>
	HCR-20 completed properly (if required)	<input type="checkbox"/>
2. Pathway to Violence	The pattern of violent behaviour is clearly described	<input type="checkbox"/>
	Protective factors are clearly described	<input type="checkbox"/>
3. Pathway to Safety and Recovery	Therapeutic interventions in relation to key patterns of risk are identified	<input type="checkbox"/>
	Early warning signs are clearly identified	<input type="checkbox"/>
	Evidence of communication of pattern of risk has occurred:	<input type="checkbox"/>
	• with consumer	<input type="checkbox"/>
	• with family or key carers	<input type="checkbox"/>
4. Review and Revise	Plan is up to date, including planned review date	<input type="checkbox"/>
	Total Score (out of 18 or, if HCR-20 is used, out of 20)	<input type="checkbox"/>

Appendix 10: useful websites

International Society of Mental Health	www.ismho.org/
Internet Mental Health	www.mentalhealth.com/p.html
HCR-20 materials and information	www.sfu.ca/mhlpi
Mental Health Commission	www.mhc.govt.nz
Ministry of Health	www.moh.govt.nz
Royal Australian and New Zealand College of Psychiatrists	www.ranzcp.org

Appendix 11: references

Berkshire Health Authority. (2002). *Report of the Independent Inquiry into the Care and Treatment of Winston Williams*. United Kingdom: Thames Valley Health Authority.

Ministry of Health. (1998). *Guidelines for Clinical Risk Assessment and Management in Mental Health Services*. Wellington: Ministry of Health.

Shea, S. C. (1998). The chronological assessment of suicide events: A practical interviewing strategy for the elicitation of suicidal ideation. *Journal of Clinical Psychiatry*, 59 (suppl 20), 58-72.

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *The HCR-20 Scheme: The Assessment of Dangerousness and Risk (Version 2)*. Burnaby, Canada: Mental Health, Law and Policy Institute, Simon Fraser University.

Appendix 12: feedback form

Please give us your reactions and comments. This will help us evaluate this seminar and refine future programmes.

Content

Please comment on the following areas:

Goals and objectives.....

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One-page overview.....

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Tool 1.....

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Tool 2.....

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Tool 3.....

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Completed tools.....

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General comments

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Method

Please comment on the following areas:

Workbook

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Myth and reality (introduction)

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Scenarios.....

.....

PowerPoint presentation

.....

Facilitation

.....

Large group discussion

.....

Small group work

.....

Completed tools.....

.....

What implementation issues do you foresee?

.....

General comments

.....

Recommendations

What would help improve the workshop?

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What was most helpful in the workshop or tools?

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What was least helpful in the workshop or tools?

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