

**Assessment and
Management of
Risk to Others
Trainee Workbook**

2006

The Mental Health Workforce Development Programme is funded by the Ministry of Health and was administered by Health Research Council of New Zealand until 31 March 2006

Published in June 2006 by Mental Health Programmes Limited
PO Box 108-244, Symonds Street, Auckland, New Zealand
Telephone 09 300 6770, Fax 09 373 2127, Email info@mhpg.co.nz

This document is available on the
Mental Health Workforce Development Programme website
www.mhwd.govt.nz

ISBN 0-908700-59-8

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.

Contents

Programme.....	2
Introduction	3
Housekeeping	4
Goals and objectives	5
Risk assessment: perspectives	6
Myth and reality.....	7
Lessons from inquiries.....	8
Static risk factors for violence.....	9
Internal risk factors for violence.....	10
Situational risk factors for violence.....	11
Approaches to risk assessment	12
Scenario 1: Alice	13
Interviewing strategies (current).....	14
Scenario 1: Alice (continued).....	16
Toolkit: one-page overview	19
Risk Management Care Plan diagram.....	20
Tool 1: accurate information (specifics).....	21
Tool 2: Pathways to violence (pattern recognition)	22
Tool 2: complete the sentence... ..	24
Tool 3: pathways to safety (recovery).....	25
Examples of individualised care plans	28
Scenario 2: Jack (inpatient).....	29
Scenario 2: Jack (outpatient)	30
Scenario 3: Pouli.....	31
Scenario 4: Zareena.....	32
Learning points: risk management.....	33
Summary.....	34
Appendices.....	35
Appendix 1: interviewing questions.....	36
Appendix 2: pattern recognition prompts	39
Appendix 3: tools 1 to 3	
Tool 1 - Current & Historical Record of Violence & Threats ..	42
Tool 2 - Pathways to Violence: Pattern Description	43
Tool 3 - Care Plan: Risk Management Components	44
Appendix 4: scenario 5 – Craig (forensic)	45
Appendix 5: HCR-20 – description	47
HRC-20 risk assessment scheme – items.....	48
Appendix 6: FAQs.....	49
Appendix 7: audit tool for risk management care plan.....	52
Appendix 8: useful websites	54
Appendix 9: references	55

Programme

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

Introduction

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.

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

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.

Risk assessment: perspectives

Is risk assessment and management an art or science?

Myth and reality

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

1. The most likely victims of violence by people with mental illness are whanau/family members. T / F
2. Most violent behaviour by people with mental illness is predictable. T / F
3. There are key symptoms of mental illness that predict violence. T / F
4. If antisocial or violent behaviour occurs when active symptoms are not obvious, the violence must arise from the individual's personality. T / F
5. The best predictor of future violent behaviour is past violent behaviour. T / F
6. It is the role of forensic practitioners to undertake violence risk assessment and management, rather than general adult mental health services. T / F

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*.

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/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.

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/passivity (Control override symptoms: the person experiences a loss of control over their thoughts, feelings or actions).
 - Jealousy/love.
 - Grandiose.
3. Hallucinations.
 - Command hallucinations, especially religious in nature.
4. Final common pathways.
 - Paranoid thinking.
 - Irritability.
 - Impulsivity.
 - Ego threatened/disrespected.
5. Emotional states.
 - General level of arousal.
 - Anger/rage/righteous indignation.
 - Blunting.
 - Fearfulness.
6. Suicidal thoughts.
7. Confusional states.
8. General attitudes.
 - Anti-social attitudes e.g. lack of empathy, remorse or guilt.
9. Lack of insight.
10. Lack of empathy for past victims.

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/withdrawal.
3. Non-adherence to with medication (where relevant).
4. Stressful or poor/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.

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.

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".

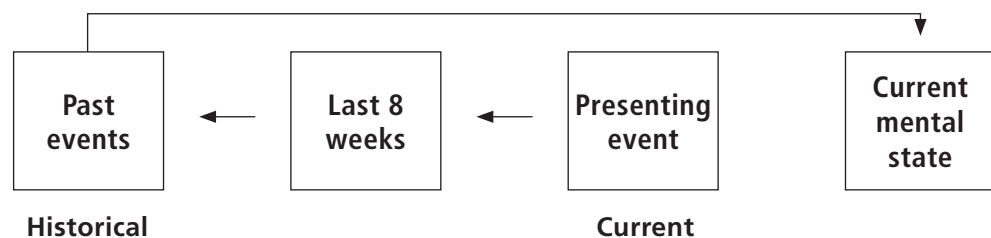
When you introduce yourself to Alice she appears aroused and fearful. Her knuckles are clenched and she is pacing up and down the room. When you identify yourself as being part of the mental health team Alice becomes angry and states, "I suppose you are going to tell me it's in the head!"

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?

Interviewing strategies (current)

1. Safety and practical considerations.
 - (a) Setting.
 - Physical lay-out important (space, triangulation).
 - Out points for each person.
 - Place of safety.
 - Level of privacy.
 - (b) Availability of support or assistance.
 - People involved.
 - Cultural considerations.
 - (c) Interviewing strategies.
 - Non-confrontational style.
 - Clarity regarding nature and purpose of interview and roles (clear boundaries).
 - Sense of control and safety for all concerned.
2. Chronological structure.
 - Structuring interview by categories of time can provide coherence, e.g. the approach developed by Shea for eliciting suicidal ideation¹.



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:

¹ Adapted from: 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.

- fearfulness
 - anger
 - entitlement
 - interpersonal conflict
 - revenge
 - jealousy
 - hopelessness.
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.
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.
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.

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 an historical record that informs risk management and how should this information be summarised?

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?

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

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 community 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?

Toolkit: one-page overview

Please refer to the one-page model on the next page, detailing the risk assessment and management process. 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.

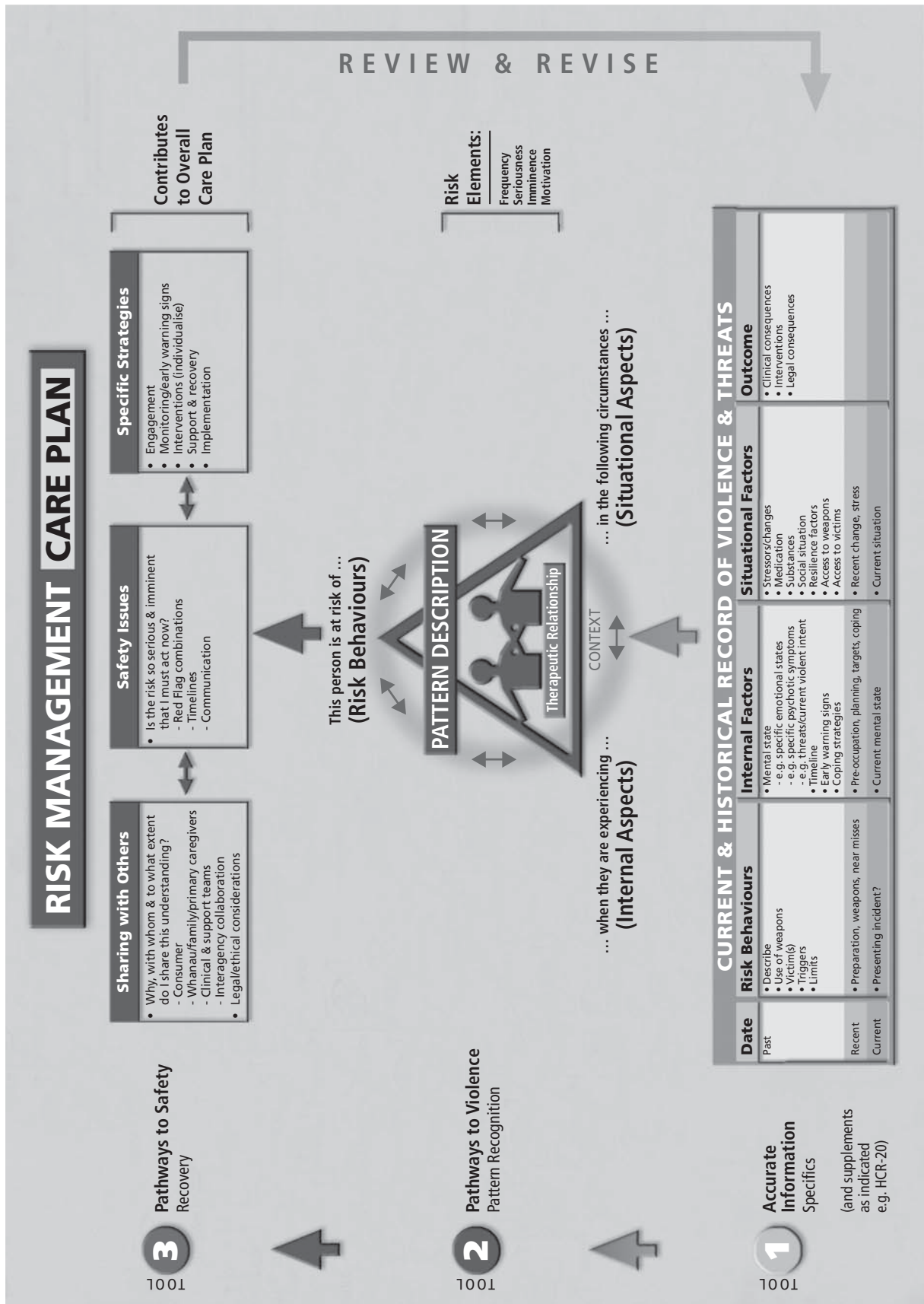
- It is a part of it.
- It does not constitute all the care plan.
- It does *not* sit outside of the care plan (conceptually).
- It may influence other components of the care plan.

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.



Tool 1: accurate information (specifics)

1. Current and historical record of violence and threats.

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. Timeframes.

- 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.

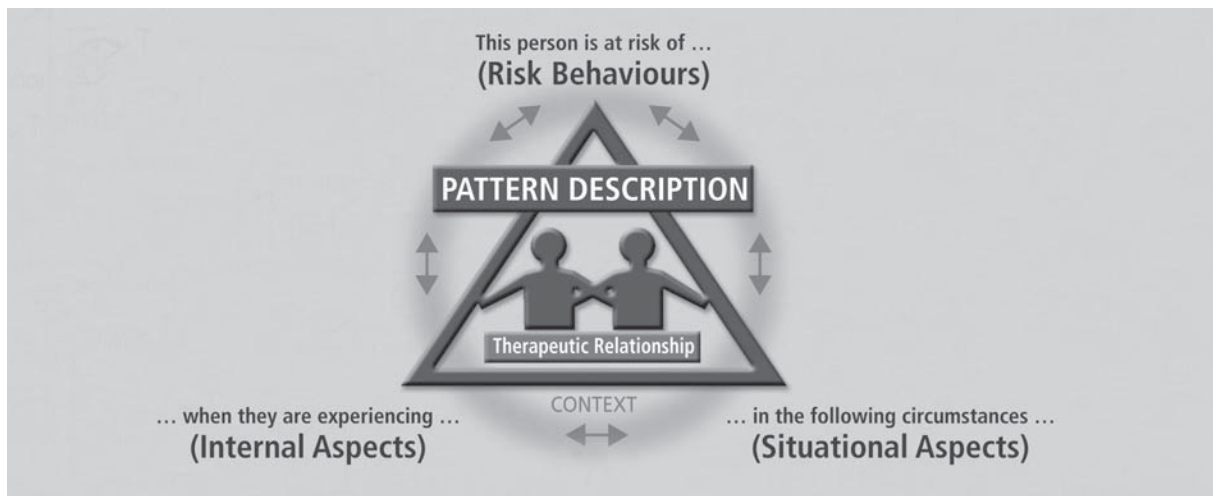
- Internal factors.
- Situational factors.

5. Sources of information.

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

Tool 2: pathways to violence (pattern recognition)

1. Pathways to violence (pattern recognition).



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.

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 ...

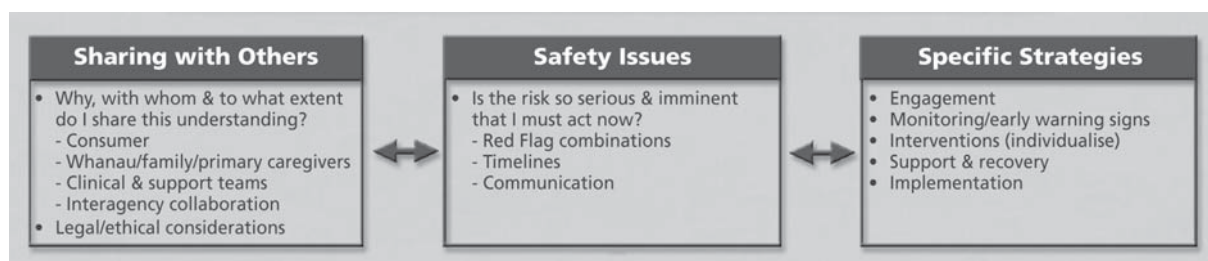
2. ... when they are experiencing ...

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

4. The following act as protective factors ...

Tool 3: pathways to safety (recovery)

1. Pathways to safety (recovery).



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).

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.

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?

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

2. The person stops taking medication.

3. The person is lost to follow up.

4. The person is in early relapse.

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.

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 last 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.

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.

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.

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?

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.

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.

Appendices

Appendix 1: interviewing questions

Appendix 2: pattern recognition prompts

Appendix 3: tools -

Tool 1: Current & Historical Record of Violence & Threats

Tool 2: Pathways to Violence: Pattern Description

Tool 3: Care Plan: Risk Management Components

Appendix 4: scenario 5 – Craig (forensic)

Appendix 5: HCR-20 – description

HRC-20 risk assessment scheme – items

Appendix 6: FAQs

Appendix 7: audit tool for risk assessment care plan

Appendix 8: useful websites

Appendix 9: references

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.

1. A presenting violent or threatening event.
2. The person's mental state, situation and behaviours over the past six to eight weeks.
3. 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 last 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 pre-meditated 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?

Tool 1: Current & Historical Record of Violence & Threats

Name:

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/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	Presenting incident?	Current mental state	Current situation	
Recent (last 6-8 weeks)	Preparation, weapons, near misses	Pre-occupations, planning, targets, coping	Recent change, stress	

Appendix 3: tools 1 to 3

Completed by: Position: Date: Next Review:

Tool 2: Pathways to Violence: Pattern Description

Name: NHI:

DoB:

This person is at risk of acting in the following way

(include acts; weapons; likely victims; seriousness):

.....
.....
.....
.....

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

(include subjective symptoms; objective signs; speed of relapse; likelihood & imminence of risk)

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

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)

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

The following act as protective factors:

- 1.....
- 2.....
- 3.....
- 4.....

Completed by: Date:

Position: Next review:

Tool 3: Care Plan: Risk Management Components

Name: NHI:

DoB:

SHARED INFORMATION / CONTACT LIST	
Individual / group (Contact details)	Information to be shared/purpose
1.	
2.	
3.	
4.	
Consumer agrees with the above information sharing Yes/no	If no, state overriding concerns:

MONITORING: EARLY WARNING SIGNS & SITUATIONS
1.
2.
3.
4.
5.

SPECIFIC STRATEGIES TO REDUCE RISK		
Strategy (General & specific)	Who?	When?
1.		
2.		
3.		
4.		
5.		

Completed by: Date:

Position: Next review:

Plan was reviewed by: Date:

Appendix 4: 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?**

Appendix 5: 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 6: 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 7: 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 used to calculate an average score (between 0 and 2) for each component of the risk assessment and management plan.

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 8: 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 9: 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.

