The Provincial Human Services & Justice Coordinating Committee (HSJCC) presents:

The HARM (Hamilton Anatomy of Risk Management) Tool: Implications for Implementation

December 13, 2013
Overview of Presentation

1. Background information about the HSJCC
2. Overview of risk assessment tools: HARM and AIS
3. Implementing risk assessment tools
   a) Forensic In-patient Units
   b) Community – Psychiatric Outreach Team
Presenters

• Sandie Leith, MSW, RSW, Director of Clinical Services, CMHA-Sault Ste. Marie Branch, Co-Chair of the Provincial HSJCC

• Dr. Gary Chaimowitz, Associate Professor, Psychiatry & Behavioural Neurosciences, Head of Service, Forensics, Centre for Mountain Health Services, St. Joseph's Healthcare

• Joan Dervin, Director, Integrated Forensic Program, Royal Ottawa Mental Health Centre, Chair of the Champlain HSJCC

• Susan Farrell, C.Psych. Clinical Director, Community Mental Health Program, Director of Training, Predoctoral Residency Program in Clinical Psychology, Royal Ottawa Mental Health Centre
HSJCC Network

- Responding to a recognized need in the province to coordinate resources and services, and plan more effectively for people who are in conflict with the law.

- Each HSJCC is a voluntary collaboration between health and social service organizations, community mental health and addictions organizations and partners from the justice sector including crown attorneys, judges, police services and correctional service providers.

- Priority consideration is for people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, and/or fetal alcohol syndrome.
HSJCC Network

HSJCC Network is comprised of

- 42 Local HSJCCs
- 14 Regional HSJCCs
- Provincial HSJCC

- Each HSJCC is a voluntary collaboration between health and social service organizations, community mental health and addictions organizations and partners from the justice sector including crown attorneys, judges, police services and correctional service providers

- Funded by the Ministry of Health and Long-Term Care
Provincial HSJCC

Provincial HSJCC consists of

- Regional HSJCC Chairs representing their Regions

- Ex-officio members from important stakeholder groups such as Correctional Service of Canada, Ontario Provincial Police and Ontario Association of Chiefs of Police, Legal Aid Ontario, and Community Networks of Specialized Care

- Ex-officio representatives from 5 Provincial Ministries:
  - Attorney General
  - Children and Youth Services
  - Community and Social Services
  - Community Safety and Correctional Services
  - Health and Long-Term Care
Tools for Assessing Risk: AIS and HARM

Gary Chaimowitz
Mini Mamak
Joan Dervin
Susan Farrell
Who we are....

Services de santé
Royal Ottawa
Health Care Group

McMaster University

St. Joseph's Healthcare Hamilton
Outline

- Introduction
- Outline of issues in the assessment and management of violence in psychiatric patients
- Description of a tool to standardize the documentation of aggressive incidents
- Description of the development of tools to guide the assessment of risk incorporating historical data as well current risk factors to formulate ST and LT risk and interventions
Objectives

- Understand the importance of accurate violence risk assessments on inpatient units and in the community
- Introduction to two tools to assess and manage risk
Risk Assessment
Risk Assessment:
- The systematic collection of information to determine the degree to which harm is likely at some point in time
- Risk Management
  - The implementation of operational procedures and supports that are dynamic and sensitive to the individual’s needs, vulnerabilities, and evolving behaviours associated with risk. The purpose of this is to minimize risk while providing safe, sound, and supportive services.
Purposes of Risk Assessment

- Predicting future risk behaviour

- Involvement in decision making
  - Processing through judicial system
  - Assessment under MHA
  - Assess suitability for rehabilitation or community placement
  - Supervision/monitoring needs
Different facets of risk:

- **Nature:** What kinds of violence are we talking about? (physical vs sexual vs. verbal)
- **Severity:** How severe will it be?
- **Frequency:** How often?
  - (isolated vs. chronic, persistent violence)
- **Immediacy:** Is the violence imminent?
- **Context:** The circumstances and victim(s)
Risk Assessment Strategies

- Clinical Judgment
- Actuarial Risk Prediction
- Structured Professional Judgment
Although it is accepted that aggression takes place in many forms and is not limited to physical attacks, risk assessment schemes tend to focus on the prediction of serious assaults.
The AIS & HARM
Aggression and Psychiatry:

- Although high incidence of violence in psychiatry:
  - Often dismissed
  - At times not documented.
- AIS developed to track and evaluate aggressive behaviour by patients.
- AIS tracks escalation of inappropriate behaviours.
Risk factors for violence in inpatient/community psychiatry settings differs from risk factors involved in prediction of violence in the general community.

Few tools assess risk within a psychiatric environment.

The HARM was developed to fill this gap.
Issues in the Management of Risk

- Limitations of current tools
  - Time consuming
  - Cumbersome
  - Complex
  - User unfriendly
Issues in the Management of Risk

- Creation of a tool yet avoid checklist Risk Assessment
- Need to differentiate between patients intrinsic risk factors….forget the psychopaths? (wink or on gurney)
- Current move to charge patients
Issues in the Management of Risk in Psychiatric Populations

- Need to be “nimble” in assessing risk
- SPJ
- How to
  - Understand why staff do not talk about risk
  - Get staff to talk about risk
  - Get staff to talk about risk in an informed fashion
  - And adjust interventions/privileges accordingly
More risk assessment tools?

- Need for a practical, user friendly tool that informs and meets needs
- Attempt to connect research literature with the clinical rock face
- Forced discussion of risk
Development of The Aggressive Incidents Scale (AIS)

Key Components:

- Simple to use: enhance compliance
- Allows ongoing assessment
- Simple to interpret: at a glance you could easily surmise the degree of aggression displayed by patient
  - Nine Point System
  - Total Aggressive Incidents Chart
  - Aggressive Incidents Intervention Calendar
- Incorporated into team report/meeting
<table>
<thead>
<tr>
<th>Level</th>
<th>Incident</th>
<th>Description</th>
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<tbody>
<tr>
<td>9</td>
<td>Critical Incident – Possible Life and Death – Possible Police Call</td>
<td>Serious violent assault or sexual assault. The victim requires medical attention. Police could be summoned</td>
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<td>8</td>
<td>Violent Unprovoked Assault</td>
<td>Impulsive interpersonal assault in which no apparent precursors are identifiable</td>
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<tr>
<td>7</td>
<td>Violent Assault</td>
<td>Aggression involves physical contact with another person</td>
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<td>6</td>
<td>Push/Shove</td>
<td>Clearly aggressive push or shove</td>
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<td>5</td>
<td>Destruction of Property</td>
<td>Aggression directed at property</td>
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<tr>
<td>4</td>
<td>Improper Physical Contact</td>
<td>Behaviour not an assault but physical contact inappropriate</td>
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<td>3</td>
<td>Intimidating, Threatening, Personal Space Violated</td>
<td>Patient’s body language and words are threatening in nature</td>
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<td>2</td>
<td>Intimidating, Raised Voice</td>
<td>Patient is verbally intimidating, possibly yelling and possibly using profanities</td>
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<td>1</td>
<td>Rude, Argumentative</td>
<td>Patient is being rude, argumentative, and possibly challenging staff authority</td>
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<th>Physical Intervention</th>
<th>Verbal Intervention</th>
<th>Police Called</th>
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  - Nine Point System: Aggressive Incidents Scale
  - Aggressive Incidents Calendar
- Incorporated into team report/meeting
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**MONTHLY TOTALS**

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**MONTHLY TOTALS**

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High user satisfaction from the AIS USQ

#1: How easy was it to get familiarized with the AIS?
- Easy: 94.5%
- Moderately Difficult: 5.5%

#2: How easy was it to differentiate the different levels of the AIS?
- Easy: 74.5%
- Moderately Difficult: 25.5%
Results: User Satisfaction

#3: Do you think that the AIS tool helps improve documentation of incidents?
- Yes: 56.4%
- Some: 36.4%
- No: 23.6%

#4: Do you think the AIS tool helps to track escalation of aggressive behaviour?
- Yes: 69.1%
- Some what: 23.6%
Summary

- The AIS is a user friendly and easy to use tool to assist in the documentation of aggressive behaviour.
- It yields excellent inter-rater reliability and user satisfaction.
The Hamilton Anatomy of Risk Management (HARM)

A method of assessing risk
Why The HARM Was Created?

- Decision To Develop Tool
- A quick and easy method
- Increase discussion of Risk
- Guide the discussion of Risk
- Formalize risk management
A structured clinical judgment tool that guides the assessor(s) to formulate opinions regarding risk of violence.

- Risk assessment is seen as a process as opposed to a calculation
- A tool that incorporates both static and dynamic factors in assessing risk as reflected in the literature
  - It is recognized that risk can potentially increase or even decrease depending on dynamic factors and rehabilitative efforts.
  - It is also recognized that risk in the short term can be different than risk in the long term.
What Is the HARM?

- A tool that incorporates discussion about how to best manage risk
- The HARM has Four Stages (past, present, risk prediction, and future-risk management)
- Several versions were created: General, Forensic, Youth and Community
The HARM-CV

A look at the tool
STAGE 1
Looking at the Past

The literature tells us that past behaviour is one of the best predictors of future behaviour (Harris & Rice, 1996, 2001).

An individual with a history of aggression, criminal conduct, and defiance will be at an increased risk for acting out violently.
## HAMILTON ANATOMY OF RISK MANAGEMENT

### FORENSIC VERSION (HARM-FV) ©

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### Historical Violence

<table>
<thead>
<tr>
<th>Past Violent Offences: list # of charges, weapons used.</th>
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<tr>
<th>Past Non Violent offences:</th>
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</table>

### Historical Risk Factors

- MMD
- PD
- Substance Use
- Cognitive Deficits
- Other (e.g. self-harm)

### Past Targets

(e.g. mother, co-worker):
<table>
<thead>
<tr>
<th>Historical Violence</th>
<th>✓</th>
<th>Number</th>
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<td>Code whites</td>
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<td>Mental Health Act Detention for Violence</td>
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<td>Criminal Record</td>
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<td>Violence on Criminal Record</td>
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<td>Conflict with Authority</td>
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<td>Weapons Use</td>
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<td>History of threatening behavior/ utterance</td>
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<tr>
<th>Historical Risk Factors</th>
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<td>MMD</td>
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<td>Substance Use</td>
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<td>Cognitive Deficits</td>
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<td>Other (eg. self-harm)</td>
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**Past Targets** (e.g. mother, co-worker):
Stage 2
What is happening now

- Dynamic Variables influence risk acuity
  (webster et. al, 2002)
<table>
<thead>
<tr>
<th>AIS Totals</th>
<th>Acute Variables</th>
<th>Change</th>
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<table>
<thead>
<tr>
<th>Acute Variables</th>
<th>Rule Adherence</th>
<th>Insight – illness</th>
<th>Depression</th>
<th>Mania</th>
<th>Psychotic Symptoms</th>
<th>Anxiety Symptoms</th>
<th>Social Support</th>
<th>Impulse Control</th>
<th>Program Participant</th>
<th>Substance Abuse</th>
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</table>
Stage 3
Risk Prediction

Taking into account Stages 1 and 2, the assessor is guided to make a determination about risk and the type of violence that is likely to occur.
<table>
<thead>
<tr>
<th>Potential Act(s) of Violence/Aggression</th>
<th>Rationale</th>
<th>Potential Target(s)</th>
<th>Duty to Protect Y/N &amp; Action?</th>
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<tr>
<th>Clinical likelihood of violence</th>
<th>Immediate (days) <em>with Profess. Support</em></th>
<th>Short-Term (weeks) <em>with Prof. Support</em></th>
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<td>Immediate (days) <em>without Prof. Support</em></td>
<td>Short-Term (weeks) <em>without Prof Support</em></td>
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<td>High o  Medium o  Low o</td>
<td>High o  Medium o  Low o</td>
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Stage 4
Risk Management

- In the final stage, the assessor(s) are guided to identify significant risk factors for the individual and to formulate a rehabilitation plan to help manage the individual’s risk.
<table>
<thead>
<tr>
<th>Risk Mgmt</th>
<th>Modifiable Risk Factors</th>
<th>Intervention</th>
<th>Team Member</th>
<th>Response</th>
<th>Privileges/Observation</th>
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Non-Modifiable Risk Factors:
Implementing the HARM: Forensic In-patient Units

![HARM-FV Form](image)

### Hamilton Anatomy of Risk Management-Forensic Version (HARM-FV)

**Name:**

**On:**

**PCU:**

**D:**

**Other:**

**Index Offence:**

**Date:**

**Other:**

**Compromised by:**

**Other:**

**In-Risk:**

**Other:**

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<th>Historical Violent Offences</th>
<th>Dates</th>
<th>Weapon</th>
<th># Charges</th>
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<th>Historical Non-Violent Offences</th>
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<th># Charges</th>
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### PAST

#### Risk Factors

- **Suicide:**
- **Personality Disorder:**
- **Substance Use:**
- **Cognitive Deficits:**
- **Other (e.g. medical condition):**

### CURRENT

#### AIS Totals

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<th>Past Month</th>
<th>Year to Date</th>
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#### Risk Factors

- **Rule Adherence**
- **Insight – Illness**
- **Mood Disorder**
- **Psychotic Symptoms**
- **Impulse Control**
- **Social Support**
- **Program Participant**
- **Substance Abuse**
- **Med Non-Adherence**
- **Average Attitude**
- **Other:**

### FUTURE

#### Clinical Likelihood

- **Of Violence**

#### Risk Management

- **Consider Modifiable and Non-Modifiable Variables**

#### Treatment Plan

| Intervention | Team Member | Response | Privilege/Obl.
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Royal Ottawa Mental Health Centre
Centre de santé mentale Royal Ottawa

University of Ottawa Institute of Mental Health Research
Institut de recherche en santé mentale de l’Université d’Ottawa

Royal Ottawa Foundation for Mental Health
Fondation de santé mentale Royal Ottawa

Brockville Mental Health Centre
Centre de santé mentale Brockville
Recognizing a Need

- Previous Risk Assessment Tool:
  - S.T.A.R.T - Implemented in 2010 in the IFP
  - AIS - Implemented in 2009-2010

Benefits:
- Regularly scheduled clinical assessments
- Oriented toward treatment and daily management of inpatients
- Intends to predict imminent risk of violence and other forms of harm (self neglect, suicide, U/L, victimization)
Challenges

• Scheduling
• Time consuming
• Staffing issues
• Under use of Information coming from assessments
• No connection between S.T.A.R.T. assessment and care planning
Contacts with Dr. Chaimowitz and Dr. Mamak

- Discussion began between Clinical Director Helen Ward and Director of Patient Care Services Joan Dervin and contacts were made with the Developing team for the Hamilton Anatomy of Risk Management
Presentation of the HARM

• Interdisciplinary “champions” volunteered for a 2 hour presentation by Dr. Chaimowitz
• Described the process of developing the HARM
• Outlined the importance of Risk Assessment in Forensic population (Stefanui vs Ahmed)
• Case examples on its use
Collaboration

Discussion on implementation strategies Between:

• Anita Bloeman (Manager of both Forensic in-pt units)
• Helen Ward (Clinical Director)
• Joan Dervin (Director of Patient Care Services)
Creating the Training Module

• Received Companion guides and HARM- Forensic Version forms
• Compiled information from Companion guides into a presentation to be used as a training module for all Forensic in-patient staff
• Training the Trainers: 2 Staff on Rehab selected as trainers, 1 on Assessment
Easing the Implementation

To ensure an easy transition:

• Trainers filled out static information on all in-patients on Rehab and Assessment
• Trainers collaborated with Anita to ensure every full time and part-time and allied health staff received training
• Trainers facilitated the initial HARMs on each of the in-patient units
Evaluating Implementation

• Trainers were collecting information, questions and concerns from staff throughout the training process and during the initial use of the HARM.
• Contacts were made to Dr. Mamak, and these questions and concerns were addressed through collaboration with the creators.
Next Steps

• Implementing the Forensic Out-patient version on the HARM
• Collaborating with Dr. Mamak and Dr. Chaimowitz as a Pilot program using the Out-pt version
• Negotiating with our TRHP to transition to HARM-Out-pt version
HARM-CV and AIS in a Community Context

Overview of Development and Initial Use with Psychiatric Outreach Team and its Partners

Susan Farrell, PhD, CPsych
Clinical Director, Community Mental Health Program
The Royal
What is the Psychiatric Outreach Team

• Multi-disciplinary psychiatric team that works in homeless shelters and related community agencies

• Dual Clients
  ▫ Persons who are homeless with mental health issues
  ▫ Agency staff who serve clients (part of education and capacity building mandate of team)
Trends we See in Client Population

In Homeless Shelters in Ottawa:

- Increasing #s of persons at both ends of the age continuum
- Increasing rates of severe and persistent mental illness symptoms
- Increasing rates of concurrent disorder
- Increasing rates of persons with cognitive delay
- Increasing violence in women’s services
Things our Partners Asked of Us

- Methods to manage risk in population
  - Needs methods to measure and understand the risk in order to start to manage it
- Working together to address risk – of all types
- Using measures and methods that work with the population we work with

We shared a growing concern and needed to address it
To manage it well, you need to measure it well

Selecting the HARM-CV for the Outreach Team
HARM-CV and AIS - Intro to Authors

- Drs Chaimowitz and Mamak presented at OPA 2011 and talked of development of a community version of a risk measurement and management tool
- They had success training a range of disciplines in forensic and other inpatient units
- They had developed a community version and were “up for the challenge” to adapt to a homeless shelter setting and its clients
Why the HARM-CV seemed a good fit

• Community version – building on research base used to develop inpatient version

• Identification of historical and current issues in determining risk and collaborative developing risk management plan

• Developed a method for common language about risk, aggression, measurement and management
History of Our Training Opportunities

- December 2011
  - Initial presentation on issues in risk assessment
- February 2012
  - Presentation on risk measurement and management and making HARM-CV fit our needs
- February 2012
  - Chance to see HARM in action at St Joseph’s Hamilton inpatient unit
- February 19, 2013
  - Chance to focus on aspects of successful risk management plans (using case examples)
Our Implementation

• Team Discussions

• Development of Pilot Project
  ▫ AIS training (adapted from Dr Mamak)
  ▫ Pre and Post evaluation questions
  ▫ AIS pilot

• February 19, 2013
• Chance to focus on aspects of successful risk management plans (using case examples)

• Ongoing discussions re: use and growing further
Model for Use

- Persons identified for HARM-CV completion selected by Outreach Team and shelter staff together

- Shelter staff complete Aggressive Incidents Scale based on their ongoing observation within shelter

- HARM-CV completed by Outreach Team staff in collaboration with shelter staff
Developing a Pilot Project

• Selected three agencies to begin project
  ▫ Management of Alcohol Program
  ▫ Brigid’s Place
  ▫ Women’s Special Care Unit

• Elements of Pilot Project:
  ▫ Questionnaires re: Risk
  ▫ AIS training
  ▫ Incidence snapshot – 3 days of AIS collection across entire site
    • Staff identified day of perceived high, medium and low aggression

• Shared findings of AIS snapshot with sites to help develop a sense of who to select for HARM-CV completion
Objectives of the Pilot Project

• To understand current shelter practices in measuring and managing risk

• To introduce AIS and HARM-CV to persons we serve
  ▫ To understand rates of aggressive incidents in shelter and their etiologies
  ▫ To examine usefulness of AIS and HARM-CV in measurement and management

• Modify HARM-CV for relevance with outreach population and environments
Initial Enthusiasm - Why?

Outreach Team
• Appreciate evidence base of HARM-CV
• Find AIS a good tool to begin discussions about a client’s behaviour
• Appreciate collaborative method to work with shelter staff

Shelter Staff
• Despite some reported confidence in assessment abilities, self-identify low level of measurement and management strategies
• Consider AIS easy to use and see its role in assessment
• Report satisfaction with collaborative method to work with Outreach Team
Initial Challenges

- Transient populations do not travel with their clinical files
- Transience – in clients and staff
- Finding time (or prioritizing time) for completion
- Consistent application of management plans
- Ongoing review of “impact” of doing things differently
Overall Lessons Learned

- Measuring risk is different than managing risk
- Both are critical conversations in care
- Collaboration with HARM authors to modify tools to match population (and evidence base)
- Diverse staff groups can (and should) be trained
- This is an adventure worth pursuing!
### Historical Violent Offences

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<th>Dates</th>
<th>Weapon</th>
<th># Charges</th>
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### Historical Non-Violent Offences

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### Historical Risk Factors
- MMD:
- Personality Disorder:
- Substance Use:
- Cognitive Deficits:
- Other (e.g., suicidal behaviour):

### Past Target(s):

### AIS Totals

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<tr>
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<th>This Month</th>
<th>Past Month</th>
<th>Year to Date</th>
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### Risk Factors

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### Clinical Likelihood Of Violence

**Immediate** (days): with professional support
- High ☐ Medium ☐ Low ☐
- Immediate: released & no professional support
- High ☐ Medium ☐ Low ☐

**Short-Term** (weeks): with professional support
- High ☐ Medium ☐ Low ☐
- Short-Term: released & no professional support
- High ☐ Medium ☐ Low ☐

### Treatment Plan

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<tr>
<th>Interventions</th>
<th>Team Member</th>
<th>Response</th>
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### Risk Management:
- Consider Modifiable and Non-Modifiable Variables
HAMILTON ANATOMY OF RISK MANAGEMENT-COMMUNITY VERSION (HARM-CV)
© Chaimowitz & Mamak (2011)

Name:                                                                   Completed By: 
Diagnosis:                                                            Agency Name: 
Date:                                                                     Length of Time at Shelter: 
Pattern: Short stay     Episodic     Chronic

Historical Risk Factors ✓ / Ø / UK
Major Mental Disorder: 
Personality Disorder: 
Alcohol/Drugs: 
Medical: 
Cognitive Issues: 
Employment Instability: 
Housing Instability: 
Financial Difficulties: 
Other: 
Other: 

Historical Violence ✓ Notes Unknown
Lack of Collateral Info
MHA Detention for Violence
Criminal Record
Violence on Criminal Record
Conflict with Authority Figures
Weapons Use
Threatening behaviour/utterances
Banned from Shelters
Section 17

Past Targets (e.g., staff, co-residents):

Past

Modified AIS
Estimations of Aggressive Incidents

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<th>Past Month</th>
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Risk Factors

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Rule Adherence 
Insight – illness
Mood Symptoms
Psychotic Symptoms
Social Support
Impulse Control
Program Participant
Substance Abuse
Med Non-Adherence
Antisocial Attitude
Other:

Suicide Risk Assessment

Immediate (days): High Medium Low
Plan: Form 1 / Form 2 / Crisis Plan/ Sect. 17 / No Action

Potential Acts of Aggression

Rationale

Potential Target(s):

Duty to Protect Y/N & Action?

Violence Risk Assessment
Immediate (days):
with mental health support: High Medium Low 
no mental health support: High Medium Low

Suicide Risk Assessment
Immediate (days): High Medium Low

Risk Management:
Management Plan
Interventions
Team Member
Response

Special Considerations
Risk Scenario

In a narrative format, please describe the scenario that could play out if your clients risk was increased:

Please speak to the following:
- What type of violence is likely to be perpetrated: physical/sexual/verbal
- Treatment compliance: current MSE
- What is he or she likely to do: physical/sexual/verbal
- Under what circumstances is the violence likely to occur
  - While intoxicated (what substance)?
  - When emotionally dysregulated or angry?
  - When refused something?
  - When off of medications and actively symptomatic?
- Suicide risk
- Duty to warn/duty to protect: who needs to be contacted (include contact information)

Example Scenario:

Mr. Forensic is a 48 year old male who is presently a patient of St. Joseph’s Healthcare, Hamilton, Forensic Service under a FORM 49: he was being deemed NCR for two counts of ASSAULT (victims: parents) in 2011. Mr. Forensic does not have a past criminal record but has had past police contacts for aggressive behaviour. Mr. Forensic failed to return from 2 hour community pass at 3pm January 13, 2013. At the time he left the hospital, he was wearing: blue jeans, red sweatshirt, and a navy blue winter jacket. He left with approximately 60 dollars on his person.
Mr. Forensic is diagnosed with Schizophrenia and is presently in receipt of an oral medication that assists in managing his psychotic symptoms. When unwell, Mr. Forensic becomes delusional (believing that others are attempting to harm him) and will experience auditory hallucinations. At the time of his escape, Mr. Forensic was treatment adherent and was not displaying any signs of psychosis. However, he does experience rapid decompensation when off his medications and he is likely to become delusional within a few days in the community. When delusional, his risk to act out violently is high. It is also noted that Mr. Forensic has a history of abusing substances (marijuana) and this is significant risk factor for him.

Mr. Forensic has few social supports in the community and as such, he is likely to contact or attend his parent’s residence during his escape. Their contact information is attached. Given his history of violence towards his parents, they should be notified of the escape and the likelihood that he will contact them. Mr. Forensic has also lived in Toronto in the past, and may travel to Toronto to meet up with past associates. He is likely to stay at local shelters if he is in the Toronto area.

Completed by: ____________________________ Date: _______________________

Updated: ____________________________
## Hamilton Anatomy of Risk Management - Youth Version (HARM-YV)

### Long Term Estimate of Risk
- **High**
- **Med**
- **Low**

### Historical Risk Factors
- **MMD:**
- **Personality Traits:**
- **Substance Use:**
- **Cognitive Deficits:**
- **Self-harm/Suicidal Beh:**
- **Home Environment:**
- **Other:**

### Historical Violent Offences
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### Historical Past Targets:

### AIS Totals

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<th>Last Period</th>
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### Current Risk Factors

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<td>Impulsivity</td>
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<td>High Aggress Drive</td>
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<td>Sensation Seeking</td>
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<td>Peer Influence</td>
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<td>Community Contact</td>
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### Forms Completed?
- **Suicide Risk:**
- **Level of Supervision:**
- **Arms Length:**
- **Constant Visual:**
- **Intermit Visual:**

### Self-Harm Incident Totals

### Suicide Gesture/Attempt Totals

### Forms Completed?

### Level of Supervision

### Protective/Strength Factors
- **Individual:**
- **Family:**
- **Environmental:**

### Violence Risk Assessment

### Suicide Risk Assessment

### Potential Behaviours:

### Duty to Protect?
- **Yes**
- **No**

### Action Taken?
- **Yes**
- **No**

### RISK MANAGEMENT: Treatment Plan / Interventions / Team Member Responsible / Response

### Privileges Onsite

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<thead>
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<th>Privileges Onsite</th>
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<td>Unescorted D</td>
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<td>Goal-Based</td>
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### Time:

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