GUIDELINES for

CLINICAL RISK ASSESSMENT and MANAGEMENT

in MENTAL HEALTH SERVICES

Ministry of Health

in partnership with the

Health Funding Authority

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Foreword

A frequent finding in inquiries into failures of mental health services, both here and overseas, is a lack of robust risk assessment and management. The language of 'risk' has become the predominant discourse, not just in clinical practice but across an increasingly wide range of government and private activities, and dealing with both the 'hazards' and the 'outrage' is an increasing necessity.

Clinical practice always carries some risk. Good clinical management requires skill, experience, and careful judgement, applied to a sound base of information and knowledge. It is vital that clinicians working in mental health services are well informed and appropriately skilled in the assessment and management of the range of risks that they are presented with. Many services and clinicians have already been active in the development of good protocols and practices. These guidelines have been written to assist in this process of development.

This project has been a co-operative venture. I would to thank the following:

- the Health Funding Authority for funding the project
- Waitemata Health, Nelson-Marlborough Health, Capital Coast Health and Healthlink South, who provided staff to participate in the working group
- the Mental Health Commission for the close collaboration between this project and their review of clinical risk management in hospital and health services (previously known as CHEs)
- the members of the working group for the skills and enthusiasm that they brought to the task
- Dr Nick Judson for his leadership and commitment to this project.

Dr Janice Wilson
Director of Mental Health

Contents

Purpose

These guidelines are written to provide a basic framework to guide and aid mental health clinicians to better assess and manage clinical risk. They cover all mental health settings and disciplines, not just acute inpatient or forensic settings, and are equally relevant to crisis teams and community-based services.

Clinical risk assessment and management occurs in the context of broader risk management – organisational, financial, political, legal and so on. These guidelines focus on clinical risk.

It is the responsibility of every mental health service to ensure that the appropriate strategies, protocols, teaching programmes and audit procedures are developed and used.

The document aims to be brief, readable and practical. It does not attempt to cover all eventualities, nor is it over prescriptive, but it sets out general principles common to all risk assessment and management. More specific information is contained in the appendices.

Introduction

There is a particular onus on the mental health clinician to assess and manage clinical risks in a way that stands up to scrutiny, and for mental health services to develop decision-making processes and competencies with regard to levels of risk and uncertainty.

Simplistic predictions of 'dangerousness'[1] are rarely useful. What is useful is a picture of what circumstances are likely to lead to an increased risk. This requires a detailed picture of the individual, the characteristics and course of the illness, details of circumstances and situations where particular behaviours or problems arise/have arisen, effective/ineffective interventions, and previous outcomes. A plan of management, based on this information, should aim to minimise risk and strike a balance of risks to the individual and to others.

Assessment is only of use if it leads to better management, and hence better outcome. Risk assessment is not complete until a formulation of risk is made and a plan of management drawn up.

The concept of risk

Definitions

Risk is the likelihood of an adverse event or outcome.

Risk factors are the particular features of illness, behaviour or circumstances that alone or in combination lead to an increased risk.

Risk assessment is an estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time.

Risk formulation is a process of summary and organisation of the risk data, and identification of the risk factors. It provides the information base for risk management.

Risk management aims to minimise the likelihood of adverse events within the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care.

[1] For example, rating an individual as 'high risk' or 'dangerous' without any contextual information.

What kinds of risk?

Risk assessment is broader than just the risk of violence to others, though this is of most concern to the public and media.

The principal categories of risk[2] are broadly:

- the risk of progression of illness – risk to health of the individual
- the risk of deliberately induced harm to self including suicide
- the risk of unintentional harm to self, or exploitation
- the risk of intentional or unintentional violence, or fear-inducing behaviour towards others.

Examples include:

RISKS TO SELF	RISKS TO OTHERS
➢ safety (including suicidal acts, deliberate self harm) ➢ health (including drug and alcohol abuse, physical harm, psychological harm) ➢ quality of life (including dignity, social and financial status) ➢ vulnerability (including exploitation, sexual abuse and violence from others) ➢ self-neglect ➢ cultural/spiritual	➢ violence (including emotional, sexual and physical violence) ➢ intimidation/threats ➢ neglect/abuse of dependants ➢ stalking/harassment ➢ property damage (including arson) ➢ public nuisance ➢ reckless behaviour (including driving)

Risks may also be posed to consumers/patients by systems and treatment itself, such as side-effects of medication, ineffective care, institutionalisation and social stigma. These risks are often neglected when considering a management plan but should be carefully considered.

Characteristics of risk

- 'Risk' fluctuates and is not a static state (hence a need for regular reassessment).
- Degree of risk does not necessarily equate to legal status.
- Assessment/prediction is more accurate in the short term (and is never 100% accurate).
- There are critical points in management of risk (see below).
- The most important way to minimise risk is good clinical management.
- Reliance upon actuarial[3] factors alone is unwise.

[2] There are similarities between these categories and those in the definition of 'mental disorder' in s2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

[3] Actuarial risks are the probabilities of risk based on the whole population estimates.

Assessment of risk

Risk assessment is an integral part of *every* clinical observation or assessment. Risk assessment does not occur on a 'one off' basis, but is ongoing, with a particular emphasis at 'critical points', such as:

- first contact with a service
- change or transfer of care
- change in legal status
- change in life events (eg, loss)
- significant change in mental state
- discharge, or move to a less restrictive environment.

All individuals presenting to, or under the care of a mental health service should be assessed for risk. The detail and specificity of such assessment will vary according to circumstance and past behaviours, but every individual should at least be screened for risk.

In urgent situations it may not be possible to assess all historical factors: a minimum includes the first two columns in the table below. Awareness of risk should be particularly high in urgent/emergency assessments.

Risk should be reassessed at regular intervals and any change in risk (increase or decrease) should be noted.

Although there is now much documentation and research, there is no foolproof system for prediction. Assessment must be based on a thorough collection of information from all available sources and cover all aspects of the illness, background, behaviour and circumstances of the individual. A full assessment should consider the factors listed in Table 1 on page 5.

Every clinician expected to carry out a risk assessment should be trained to do this. Assessments should be made by staff with appropriate skills, cultural expertise and gender. Interpreters should be used if required. Services should ensure that staff know when to seek a more specialised assessment (eg, from forensic services or cultural specialist).

The background of the assessor (attitudes, gender, culture, age) and the circumstances of the assessment will impact on the outcome of the assessment.

Table 1: Factors to consider when assessing risk

MENTAL STATE	ENVIRONMENT/CURRENT FACTORS	HISTORICAL INFORMATION
Behaviour • Dangerous or threatening actions • Verbal/non-verbal risks • Deliberate self harm • Aggression **Affect** • Arousal, anger, hostility, irritability, suspiciousness, fear • Low mood or elevated mood **Cognition** • Thoughts or fantasies of deliberate self harm or harm to others • Persecutory thoughts, delusions • External control • Confusion • Preoccupation, obsession, jealousy • Control over-ride • Cultural beliefs **Perceptions** • Command hallucinations (especially linked with delusional beliefs) • Misidentification • Matakite[4]	**Immediate stressors** • Substance use, intoxication or withdrawal • Relationships • Presence or absence of support • Presence/absence of treatment, non-compliance with treatment • Persecution or threats from others • Arrest or criminal charges • Loss including death of a peer • Cultural transgression • Financial stress **Access** • To weapons, pills, victims **Situation** • Home, prison, hospital, etc **Individual's attitude** • Co-operation • Refusal to co-operate (including fear of compulsory treatment process)	**Illness and incidents** • Patterns of illness • Psychiatric history • History of incidents (and context) • Treatment and outcomes • Features of past crises • Personal history **Personality** • Usual coping style **Family background** • Demographics, age, sex • Culture • Dynamics

Limits of risk assessment

It is not possible to identify and eliminate risk entirely. Even in the best of circumstances, and using the most carefully applied assessment and management methods, adverse events will still occur from time to time. The objective of good clinical risk management is to minimise the likelihood of an adverse outcome.

Clinical risk assessment has aptly been compared with weather forecasting. A weather forecast is not 100 percent accurate all of the time. It should provide a reasonable estimate of the likelihood of various weather events (eg, rain) for us to make an informed judgement of what to do (eg, take an umbrella or risk getting wet).

Actuarial tests[5] are able to identify high risk *groups*. Extreme caution is required when applying probabilities derived from actuarial methods to *individuals.*

[4] Spiritual connection with ancestors.

Sources of information

Assessment of risk is based on:

- factual information *and*
- informed opinion.

Good assessment requires an adequate database. Sources of information should include:

- the individual
- other informants (eg, family, friends, work colleagues)
- previous clinical records
- other health sources (eg, GP)
- police and Court records.

Great weight should be given to information and opinion gained from those who know the individual well, whether they are family, friends or staff.

Particular care must be taken to ensure that the information on which assessment is based is accurate.[6] This will often involve going back to the original record, rather than relying on possibly distorted summary reports or what was said to have happened. Always look for objective and verifiable data sources where possible, and first-hand accounts if they are available.

Information should be checked with the individual client unless there are valid reasons not to do so (see Appendix 4).

The Privacy Act 1993 and the Health Information Privacy Code 1994 should not be seen as impediments to obtaining information (see Appendix 4).

[5] See above, footnote 3.
[6] The acid tests of information are sufficiency, relevance, competency and timeliness.

Formulation of risk

Formulation summarises the risk data and sets the stage for a management plan. It acts as a check that an adequate assessment has been done. The process of formulation ensures that there is an opportunity to *think* about the risk.

Background

- Relevant demographic characteristics
- Culture
- History of violence/deliberate self harm/other behaviour

Current situation

- Current sources of stress/current environment
- Precipitating events and circumstances
- Comparison of current context, stressors and circumstances to previous contexts, stressors and circumstances

Risk factors

- Identification of relevant risk factors
- Prioritisation of risk factors

Risk statement

- Nature and magnitude of likely event
- Probability of adverse event
- In what circumstances, and what precipitants
- Imminence of risk
- Means/access

- ***How long is this assessment valid for?***
- ***When is the next assessment due? By whom?***

It is useful to indicate a level of concern (eg, high/medium/low) for the overall assessment, but this is only helpful if used in the context of a qualitative formulation of the risk factors and the circumstances of each.

Management of risk

The aim of risk management is to identify appropriate actions, implement these, and then evaluate the outcomes of the risk management plan. Risk management plans should be integrated into the overall clinical management plans for each individual.

Where risk is identified, the management plan should address the *immediate* risks, *ongoing* management and future *preventive* actions, taking into account the context, the opportunity, means and motivation.

Risk management plans should include contingency plans to deal with likely risk scenarios, which should be communicated to family or other 'informal' carers.

Balance of risks

In order to achieve therapeutic gain, it is sometimes necessary to take risks. A strategy of total risk avoidance could lead to excessively restrictive management, which may in itself be damaging to the individual.

Clinical decisions must be based on a thorough and sound analysis of risks and benefits. Achievement of beneficial outcomes and minimisation of harm requires a careful judgement of the compromise between various clinical factors.

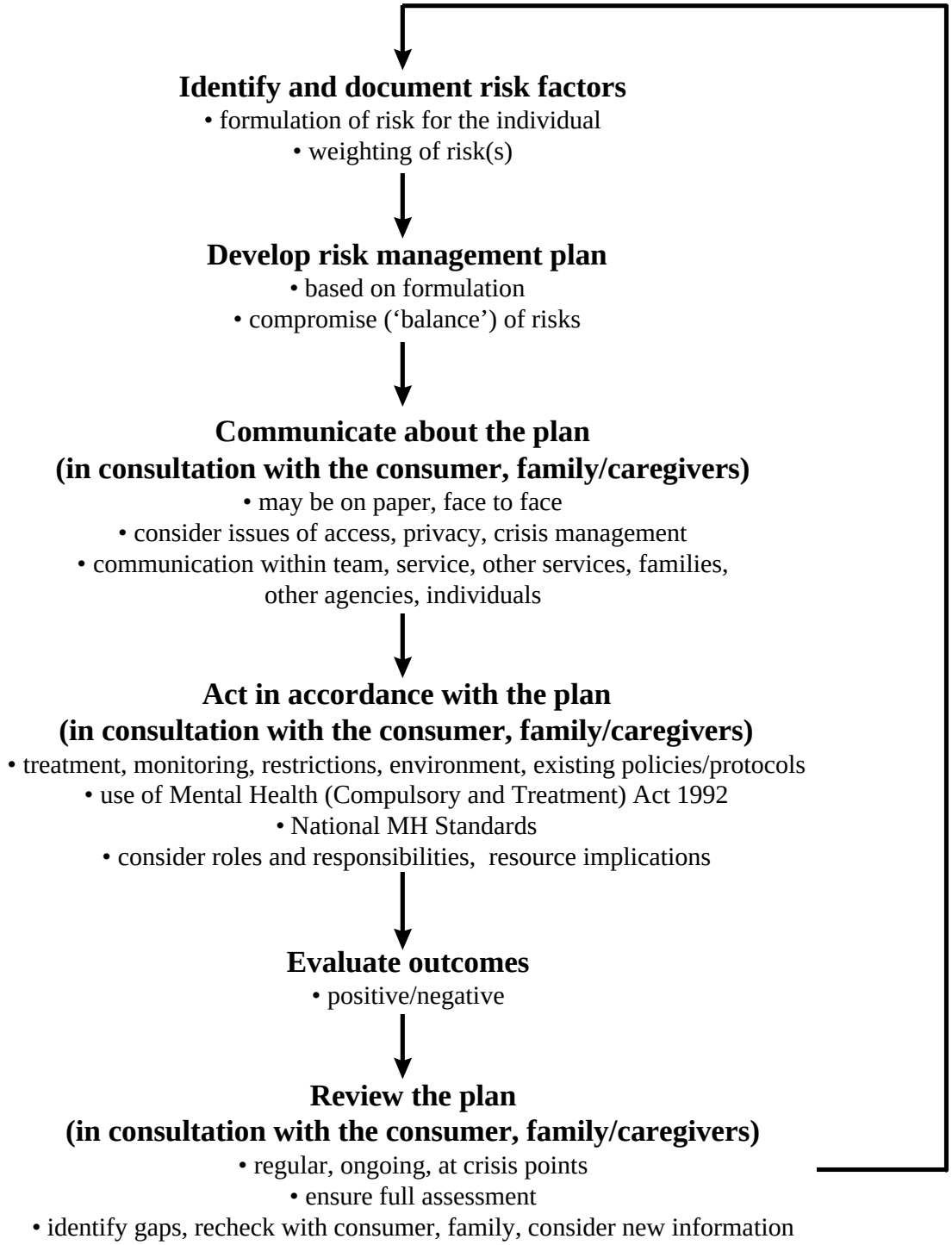
The process of balancing risk and benefit must be carefully documented.

High risk

In addition to the general risk management systems described in these guidelines, a specific system may be appropriate for individuals identified as posing a particularly high risk.[7]

[7] *Report of the Working Party for Improving the Management of High Risk Mentally Ill Patients*: Dept of Health, 1991.
This report recommended that each mental health service should implement a system to ensure that those individuals who present a particularly 'high risk' are identified and entered into an appropriate clinical management system that provides additional safeguards to manage the risk.

The process of risk management planning



Documentation and transfer of information

Recording of risk assessment and management should be incorporated into the clinical record. Although risk issues require specific documentation, this should not be separated from the rest of the clinical documentation.

These guidelines do not attempt to prescribe a single format for recording risk assessment and management planning. Each service should develop a format that is consistent with the clinical documentation used by the service. Documentation is more likely to be completed if there is a specific format. Mechanisms that highlight a very high level of clinical risk may be needed.

Risk management plans must be clearly written, up to date, and readily accessible to any clinician involved in the management of the individual. Particular care must be taken to ensure that:

- management plans are readily available to crisis teams or others who may be called in a crisis
- sufficient, accurate and timely information is available to others concerned in the care of the individual to enable appropriate provision of care and minimisation of risk.

Relevant information and records must transfer with patients moving between services (note s 127(8) of the MHA[8]). ***It is vital that information on risk is communicated to others involved in the care of the individual.***

[8] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 127(8) states: 'On the transfer of a patient from one hospital or service to another in accordance with any provision of this Act, a copy (certified to be a true copy by or on behalf of the person in charge of the hospital or service from which the patient is transferred) of the compulsory treatment order, and of the medical certificates and of the copy of the application that accompanied the order, or of any other instrument of authority under which the patient was admitted or detained, shall be delivered to the person in charge of the hospital or service to which the patient is transferred, together with such copy of the clinical records of the patient as may be appropriate or an adequate summary of the clinical condition of the patient immediately before the patient's transfer.'

Cultural issues

In assessing and managing risk, as with any other clinical situation, care should be taken to consider cultural issues, such as:

- accurate communication
- different concepts
- language
- reluctance to disclose, or shame of disclosure
- tolerance and management of risk
- involvement of family/whänau and hapü/iwi
- involvement of tohunga.

It is important, wherever possible, to involve someone who is of the individual's own culture when carrying out an assessment, or planning management.

Mental health services should provide staff training in cultural psychiatry and cross-cultural communication issues, and should employ staff specifically to advise on appropriate cultural management.

(see appendix 5)

Bibliography

The British Journal of Psychiatry Vol. 170 (Supp. 32) and International Review of Psychiatry Vol. 9 (2-3). have published useful special editions on risk assessment. The following list includes references cited in these guidelines and useful further reading. Those marked * are particularly recommended to the general reader.

Risk Assessment and management generally

Bacon, Paul (**1997**) *Assessing risk: Are we being overcautious*? British Journal of Psychiatry Vol. 170 (Supp. 32) (30-31).

Bingley, William (**1997**) *Assessing dangerousness: Protecting the interests of patients.* British Journal of Psychiatry Vol. 170 (Supp. 32)(28-29).

Buchanan, Alec (**1997**) *Assessing risk: Limits to the measurement of the target behaviours.* International Review of Psychiatry Vol. 9 (2-3)(195-200).

Carson, David* (**1997**) *Good enough risk taking*. International Review of Psychiatry Vol. 9 (2-3)(303-308).

Duggan, Conor (**1997**) *Assessing risk in the mentally disordered.* British Journal of Psychiatry Vol. 170 (Supp. 32)(1-3).

Reed, John (**1997**) *Risk assessment and clinical risk management: The lessons from recent inquiries.* British Journal of Psychiatry Vol. 170 (Supp. 32)(4-7).

Snowden, Peter (**1997**) *Practical aspects of clinical risk assessment and management.* British Journal of Psychiatry Vol. 170 (Supp. 32)(32-34).

Vinestock, Morris* (1996) *Risk assessment. "A word to the wise"?* Advances in Psychiatric Treatment, Vol. 2(1)(3-10).

Risk of Violence

Wessely, Simon (**1997**) *The epidemiology of crime, violence and schizophrenia*. British Journal of Psychiatry Vol. 170 (Supp. 32)(8-11).

Taylor, Pamela J* (**1997**) *Mental disorder and risk of violence.* International Review of Psychiatry Vol. 9 (2-3)(157-161).

Monahan, John (**1997**) *Actuarial support for the clinical assessment of violence risk.* International Review of Psychiatry Vol. 9 (2-3) (167-169).

Monahan, John & Steadman, Henry (Eds) (1994) *Violence and mental disorder: Developments in risk assessment*. University of Chicago Press; Chicago.

Monahan, John & Steadman, Henry (1996) *Violent storms and violent people: How meteorology can inform risk communication in mental health law*. American Psychologist; Vol. 51(9)(931-938).

Mullen, Paul (1997)* *The dangerousness of the mentally ill and the clinical assessment of risk.* in Psychiatry and the Law. (Brookbanks, Ed) Brooker's, NZ.

Mullen, Paul (1997) *A reassessment of the link between mental disorder and violent behaviour, and its implications for clinical practice.* Australian and New Zealand Journal of Psychiatry; Vol. 31(1)(3-11).

Petch, E. & Bradley, C (1997) *Learning the lessons from homicide inquiries: adding insult to injury?* Journal of Forensic Psychiatry. Vol. 8(1)(161-184).

Prins, Herschel (1996) *Risk assessment and management in criminal justice and psychiatry.* Journal of Forensic Psychiatry. Vol. 7(1)(42-62)

Suicide Risk

Appleby, Louis (1997) *Assessment of suicide risk.* Psychiatric Bulletin, Vol. 21(193-4).

MacDonald, Fiona (1994) *Suicide risk: a guide for primary care teams and mental health staff.* Northumberland NHS Trust, Morpeth UK.

Ministry of Education & National Health Committee (1998) *Young people at risk of suicide: a guide for schools.* Ministry of Education & National Advisory Committee on Health and Disability, Wellington.

Morgan, G (1997) *Management of suicide risk.* Psychiatric Bulletin, Vol. 21(214-6).

Appendix 1: Risk of harm to others

Violence and mental illness

In summary, the current state of knowledge about the risk of *violence* from those with a mental illness is as follows.[9]

- The great majority of mentally ill people present no greater danger to others than the general population.

- The best predictors of offending among mentally disordered people are the same as those for the rest of the population, such as their previous record of offending, or threats.

- The risk posed by people with a severe mental illness, such as schizophrenia or manic depressive disorder, is increased when they are experiencing active psychotic symptoms.

- The risk of violence is further increased for those with severe mental illness who have active symptoms, and also misuse drugs or alcohol.

- The relative risk posed by people with mental illness is of the same order as that posed by the general population aged between 18 and 24 years. It is lower than the risk presented by young males from lower socio-economic backgrounds, and is lower than the risk presented by people who misuse alcohol or other drugs.

Overall, there is a moderately increased risk of violent or fear-inducing behaviour among those who have mental illness.

The increased risk appears to be almost entirely due to active, untreated symptoms of illness, including non-compliance with medication. The best way to control the risk is to ensure that there are effective monitoring systems that can detect early signs of relapse, and ensure ready access to services that will deal with these promptly.

[9] See:
Mullen, P (1997) *A reassessment of the link between mental disorder and violent behaviour, and its implications for clinical practice.* Australian and New Zealand Journal of Psychiatry; Vol. 31(1) 3-11.
Reed, J (1997) *Risk assessment and clinical risk management: The lessons from recent inquiries.* British Journal of Psychiatry; Vol. 170 (Suppl 32) 4-7.
Taylor, P (1997) *Mental disorder and risk of violence.* International Review of Psychiatry; Vol. 9(2-3) 157-161.

Assessing the risk of violence

Clinical history	Course and characteristics of illness Personality, development Family background, individual circumstances and so on.
A history of risk behaviour	Violent acts? Threats? Other relevant offences? Danger to self? ➢ DETAIL behaviour, circumstances and outcome. ➢ Use primary sources if possible, or reliable summary information. Escalation of risk? Specific trigger factors or circumstances? Recognisable patterns of concern? Use of weapons? Access to weapons? Planning/foresight?
Victim characteristics	Specific victims? Likely victims – are they aware of the risk? Access to potential victims?
Early warning signs	Patterns of illness/behaviour? Later warning signs?
Interventions:	What is or is not effective? Can the risk be contained?
Specific abnormalities of mental state associated with risk	For example: command hallucinations, morbid jealousy.

Appendix 2: Suicide

This section is not intended to be a detailed manual of assessment and management of suicide. *See existing guidelines.*[10]

Prediction of suicide

There is no certain method of predicting suicidal behaviour. While risk factors are relatively common, suicide is an uncommon event. There are patterns of past and current factors that are strongly suggestive and which should alert a clinician to possible suicide risk.

While epidemiological and actuarial factors estimate the likelihood of suicide in populations, they are poorly predictive of individual behaviour. Clinicians should maintain a high index of suspicion for suicidal behaviour.

Predisposing risk factors include:

- family history of suicide or mental illness
- borderline or impulsive personality
- social and educational disadvantage
- isolation, lack of support
- past sexual or physical abuse
- unhappy family or childhood background
- depression
- schizophrenia (NB: risk is similar to affective disorder)
- substance misuse
- past history of suicidal intent/behaviour.

Protective factors include:

- an optimistic outlook (by the individual)
- good current mental health care
- responsibility for children
- strong social supports (as seen by the individual)
- supportive caregivers/parents.

[10] For example, *Guidelines on the management of suicidal patients*: Department of Health July 1993

Precipitating factors

Precipitating factors are those that can 'tip the balance', and include:

- interpersonal stresses such as the break-up of a relationship
- recent loss or separation
- anniversaries or reminders of deaths or loss of others
- imprisonment or threat of imprisonment
- school or work problems
- unwanted pregnancy
- recent move
- job loss
- exposure to suicidal behaviour (eg, peer suicide for adolescents)
- cultural issues (eg whakamaa – shame)
- intoxication with alcohol or other drugs.

Note the following

1. Suicide attempts that occur while under the influence of alcohol or other drugs should be taken just as seriously as others (and re-assessed when the individual is sober).

2. Those who have made *any* previous attempt are at significantly higher risk of suicide. A history of unsuccessful suicide attempts is often taken as an indication of lack of 'true' suicidal intent. This is a myth. Particular care should be taken to assess those who have previously attempted suicide, particularly if the attempt was potentially lethal.

3. The assessing clinician should enquire specifically about suicidal thoughts, fantasies or intent. Raising the subject of suicide is *not* likely to put the idea into someone's head; it may provide valuable information.

4. Always seek information from sources other than the individual (eg, family or friends). Someone with serious suicide intent may not always be open about this, but it may be more apparent from their behaviour.

Appendix 3: Risk through vulnerabilities

Individuals may be particularly vulnerable to dangers or exploitation at certain periods of their illness, particularly when their judgement is seriously impaired. Such dangers may include:

- exploitation – sexual, financial, occupational, family
- financial mismanagement
- serious neglect of self-care
- serious social embarrassment.

Such risks should be taken seriously as they may have severe and long-lasting effects on the individual and their family.

In addition to the guidelines above, consider:

- advance directives – (ie, how does the individual view the risk when they are well and what threshold do they see as appropriate for intervention?)

- the views of legal guardians or caregivers, where appropriate.

Note:

(a) The Mental Health (Compulsory Assessment and Treatment) Act 1992 may well apply in these situations.

(b) Use of the Protection of Personal and Property Rights Act 1988 (welfare guardianship) may be an appropriate measure for those who are particularly vulnerable.

Appendix 4: Privacy concerns

Collecting information from someone other than the individual concerned

The Health Information Privacy Code 1994[11] (HIPC) states that information should be sought directly from the individual wherever possible. Some information about risk, particularly of risk to other people, may only be fully gathered from other sources – this is permitted when it is necessary to do so. The individual should be told what sources of information have been used. *HIPC Rule 2*

Disclosure of health information

Information may be disclosed against the wishes of the individual if necessary to prevent or lessen a serious threat to public health or safety or to the life or health of the individual or another individual. Safety must be an overriding concern. *HIPC Rule 11 (2)(d)*

Unsolicited information

There are no barriers to the gathering and recording of unsolicited information if this is relevant. The HIPC does not regulate the receipt of unsolicited information. However, once it is held by an agency, it is subject to rules about storage, accuracy, use and disclosure which are contained in the HIPC. It is good practice to note the manner in which such information is received. Verification with the patient may be appropriate.

Maintenance of the law

Information may also be disclosed if it is required or authorised by law. For example:

- sections 22C and 22F of the Health Act 1956 provide for the disclosure and transfer of information for diagnostic and other purposes, subject to the provisions of the Health Information Privacy Code 1994
- s62 of the Health and Disability Commissioners Act 1994 provides for the disclosure of information to the Commissioner for the purposes of an investigation
- requests for documentation may also be made under the Official Information Act 1985.

[11] The Health Information Privacy Code 1994 and the Privacy Act 1993.
See also *Mental Health Professionals and Patient Information: Guidance Notes for Agencies in the Mental Health Sector*. Privacy Commissioner, September 1997.

Duty to protect a third party

Disclosure of information to another about a patient by a clinician may be justified. Whether this can be elevated to a duty to disclose information about patients to avoid physical harm to third persons is a topic that has not been conclusively resolved in New Zealand. There have been some helpful statements in cases which give guidance on this matter but are not binding in law. In particular, it has been said that a clinician might be justified in disclosing information about a patient when the clinician learns 'that another's life is immediately endangered and urgent action is required' *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at p 521.

Some headway has been made on this issue in the USA. In *Tarasoff v Regents of University of California* (1976) 551 P 2d 334 it was held that a psychologist had a duty to warn a potential victim of harm that was likely to be inflicted by a patient of the psychologist. The patient had told the psychologist of his intentions to kill the victim, and it was held that the confidential nature of the clinician/patient relationship did not prevail over the wider interests of society and the greater interests of the victim.

Should a New Zealand clinician be faced with a situation where disclosure to third parties may be necessary, the following steps are recommended:

1. He/she should discuss the issue with the patient.
2. He/she should attempt to gain consent from the patient to disclose the information.
3. He/she should immediately seek advice from senior professional colleagues and from their relevant professional defence body.
4. He/she should only disclose enough information to protect the third party. It would be rare that disclosure of psychiatric information would be required.
5. Information should only be disclosed to the particular authority that the clinician identifies as having the capacity to protect the third party.
6. The obligation to warn the third party may be passed on to the authority in (3) above. However, the clinician should ensure that the transfer of this obligation is clear.

It may be helpful to inform the patient of the limits of confidentiality at the commencement of the professional relationship.

Appendix 5: Cultural Issues

"Nau te raurau naku te raurau, whai te maramatanga, ka ki te kete o te hau ora"
(With combined baskets of knowledge, enlightenment will follow and good health maintained)

Tiriti o Waitangi - Treaty of Waitangi (1840)

The Treaty is an agreement entered into by two equal partners (the Crown and the Mäori tribes) and is therefore equally binding on both.

Within the principles of the Treaty exist a prescription and definition for the presence of development and provision of health services encompassing empowerment of consultation, partnership, protection, and participation.

Within these principles, good faith, honour, and respect provide the solutions to effect biculturalism, cultural safety, and an opportunity to acknowledge and accept differences.

The rights and obligations of the Treaty preserve and protect Mäori culture, value and belief systems, which are fundamental elements of Mäori well-being.

The following are suggestions as to how services may integrate, in a meaningful way, the Treaty of Waitangi:

1. Cultural personnel towards an integrated service

Employ tangata whenua who are trained in the area of mental health and tikanga Mäori to assist within this kaupapa of ' risk assessment' and 'risk management'

Establish a roster of trained Mäori mental health workers to be part of the mental health clinical assessment and evaluation of 'at risk' situations.

Seek the assistance of the kaumatua (koroua/kuia) with their wisdom, knowledge and expertise in 'te reo', 'taha wairua', 'tikanga and kaupapa Mäori'.

Tangata Whenua to provide cultural education and training.

Seek the support of the tangata whenua if and when it is possible.

Establish a cross-functional network and link with the Mäori community and marae.

2. Communication

Recognise the differences in cultural nuances of language, the cognition and perceptions from a cultural perspective.

Utilise the skills of the cultural worker/kaumatua in the communication and assessment process.

Seek the assistance of an interpreter in the absence of a cultural person.

Exercise cultural sensitivity and understanding in situations of non-verbal communication where non-responses or 'silence' is not necessarily pathological, but may be determined and understood by cultural perceptions of whakamaa/shame of disclosure.

3. Conceptual differences

Identify and differentiate cultural manifestations of behaviour such as 'matakite' as opposed to pathological syndromal features of a western mental illness.

Document elicited information pertaining to disclosed or known transgressions of tapu/sacred entities which can only be resolved through mediation of a cultural process.

Practice cultural sensitivity and safety measures which are inherently important in the assessment and management of individuals perceived to be 'at risk'.

4. Integrated treatment and management modalities

Implement treatment and management plans in consultation with the cultural worker, elders, whanau and tohunga (as requested) if cultural manifestations of 'at risk' behaviour persists.

Utilise the marae environment in addressing the cultural manifestations and phenomenon of 'matakite', 'mate Mäori', and 'makutu'.

Liaise with cultural teams from other mental health agencies and medical records to assist in collating of pertinent information.

Respect the whanau's request in enlisting the expertise of a tohunga in identifying ongoing cultural phenomenology which manifest and precipitate 'at risk' behaviour.

Actively encourage treatment measures and management from a cultural perspective, in consultation with the clinical team.

5. Confidentiality/consent

Consult with the whanau, elders of the hapu and iwi to determine the causative factors of 'mental instability' in addressing any implications of 'tapu and noa' concepts and eventual integrating a treatment and management plan.

Appendix 6: Working group

Nick Judson (Chair)	Deputy Director of Mental Health
Stephen Allnutt	Forensic psychiatrist, Mason Clinic
John Allen	Community Nurse, Nelson- Marlborough Health
Rebecca Chaplow	Cultural co-ordinator, Mason Clinic
Mark Earthrowl	Forensic psychiatrist, Capital Coast Health
Julia Hennessy	Health Funding Authority
Pauline Hinds	Consumer, Dunedin
Paul Hobbs	Psychiatrist, Healthlink South
Jo-Anne Vaughan	Schizophrenia Fellowship, Golden Bay
Barry Welsh	Consumer, North Canterbury
in liaison with	
Christopher Carroll	Mental Health Commission
Christine Elliot	Health Funding Authority
assisted by	
Catherine Coates	Senior Analyst, Ministry of Health
Lisa Williams	Analyst, Ministry of Health