Learning Centre
Queensland Centre for Mental Health Learning

QC30 Violence Risk Assessment and Management

VRAM Tool Training Example – Adult (stalking)

This example VRAM tool is for educational purposes only.
It depicts a fictional person and demonstrates how the VRAM tool may be completed. It is intended for clinicians working in mental health settings.

Content advice: this resource contains descriptions of violence.
Please look after yourself. If you find yourself experiencing distress, please reach out for help.

Organisation	Number	Support available
Lifeline Australia	13 11 14	A free 24-hour telephone crisis support service providing suicide prevention services, mental health support and emotional assistance.
Employee Assistance Program (EAP)	1800 604 640	A confidential wellbeing resource, available 24/7 to help employees find answers to questions about work, life, health, family or money.
1800RESPECT	1800 737 732	A 24-hour free information and counselling service for people impacted by domestic, family or sexual violence.
DVConnect	1800 811 811	A free 24-hour crisis support line for anyone impacted by domestic and family violence
13YARN	13 92 76	A support line for Aboriginal and Torres Strait Islander people who are feeling overwhelmed or having difficulty coping.
Kids Helpline	1800 55 1800	A 24-hour free counselling service for young people aged between 5 and 25.
Rainbow Sexual, Domestic and Family Violence Helpline	1800 497 212	An external, free and confidential support service for LGBTIQA+ individuals experiencing sexual, domestic, or family violence. It offers immediate crisis assistance, counselling, and referrals.

Queensland Government

Mental Health Services
Violence Risk Assessment and Management

Facility: COMMUNITY CLINIC

STALKING

TRAINING EXAMPLE

Family name: BROWN

Given name(s): Sam

Date: 2/1/2026

Sex: ☒ M ☐ F ☐ I

Mental Health Act status

☐ None	☐ Forensic order (mental health)	☐ Treatment support order	☐ Transfer recommendation
☐ Examination authority	☐ Forensic order (disability)	☐ Person AWA (interstate)	☐ Classified (involuntary)
☐ Examination/judicial order	☐ Forensic order (criminal code)	☐ Recommendation for assessment	☐ Classified (voluntary)
☒ Treatment authority			

Conditions of order:
Nil of note.

☐ An interpreter was used

Purpose of assessment (note clinical rationale, referral reference, factors requiring action, and the goal of the assessment)

To explore the drivers of one previous episode of **alleged stalking behaviour and threats of homicide** towards Mr Brown's (now former) neighbour which occurred from July 2025 until October 2025 and determine ways of preventing future occurrences.

Background summary

Provide relevant context (see Longitudinal Summary and update as needed). Consider:

- Age
- Diagnosis, symptoms and medication
- Psychiatric history
- Substance use
- Forensic history and current legal issues
- Risk history

Mr Brown is a 35-year-old single male who has resided alone in Department of Housing (DOH) accommodation since early 2025. Prior to this he had periods of homelessness and a history of frequently moving across short stay rentals. He is unemployed and received the Disability Support Pension (DSP).

Mr Brown is managed under a Treatment Authority (TA) in the community. A diagnosis of delusional disorder was initially made in 2025, following charges for stalking and his first episode of mental health care inclusive of an 11-week inpatient admission. There is ongoing cannabis and alcohol use. He is being treated with paliperidone 100mg monthly IMI and olanzapine 5mg nocte PO.

Mr Brown's lawyer has referred him to the Mental Health Court (MHC) for **outstanding charges** for 1 x **unlawful stalking uses/threatens violence** from July 2025 until October 2025.

Mr Brown's **forensic history** includes: 2 x possessing dangerous drug [cannabis], possess utensils or pipes and fail to appear.

Mr Brown has no history of self-harm, suicide or absconding.

He is in good physical health with no relevant medical history noted in Viewer, ieMR or CIMHA.

Mr Brown's parents are both deceased and he is the youngest of two. His brother resides interstate.

Consumer's previous violence/other problem behaviours and the context in which they occurred (note first known violence including domestic/family violence; problem behaviours e.g. stalking, fire setting and threats; any pattern; increasing frequency or severity of harm; evidence of weapon use; and details regarding previous victims)

Mr Brown had known the neighbour (alleged victim of stalking) since March 2025, soon after Mr Brown moved in, and he introduced himself to his new neighbour. Mr Brown requested the neighbour move a fence they shared on their boundary (which the neighbour did not agree with) and made derogatory statements to the neighbour about his sexuality, e.g. that he 'batted for the other side'.

Mr Brown is alleged to have engaged in the following behaviours from July 2025 to October 2025:

- Throwing rocks on the alleged victim's roof while yelling profanities and making threats 'I'm going to smash it up. Burn you'.
- Playing loud music on the property line of the alleged victim and screamed 'You're a sicko, you're a weird one'.
- Was yelling out the neighbour's name and screaming 'You're a devil. Just see what happens to you. Go on, you. Just get back inside and hide'.
- Yelled at the neighbour on several occasions in what the file notes describe as '*a nonsensical way*'.

In addition, it is alleged that Mr Brown made the following homicidal threats involving the alleged victim:

- Leaving a letter on the neighbour's doorstep which included threats: 'I will murder you. Buying a shot gun which I will use on you'.
- Making loud verbal threats to the neighbour 'I'm going to burn you. I'm going to burn him out. That is a threat. I hope you hear'.
- The following week he was burning rubbish in a homemade firepit (another neighbour assisted Mr Brown to extinguish a minor fire) while chanting, 'You will burn, you dirty slob. I am going to burn you'.

On 28/10/2025 a medical review noted that Mr Brown was '*stressed out, feeling unwell and particularly scared of 'this weird sicko' (who he clarified was his neighbour). That the neighbour was plotting to 'destroy' Mr Brown who 'knew too much' about the 'ring' and that his neighbour was going to kill Mr Brown'.* At the time, Mr Brown was described as experiencing paranoid delusions, psychomotor agitation and rapid speech. He believed the neighbour had been monitoring him for the past few months with CCTV cameras, using AI to monitor his movements and had moved things around inside his house when he went out to the pub.

Mr Brown's brother, Jake (who resides in NSW) reported on XX/XX/XX that Mr Brown had not engaged in any other stalking type behaviours, had no history of any other violence or forensic history (other than what is outlined above).

Information obtained for the VRAM from the Queensland Health Victim Support Service (QHVSS) on XX/XX/XX suggests the alleged victim continued to experience flashbacks and nightmares and has moved to a location far away from Mr Brown. The alleged victim is 'very sure' Mr Brown no longer knows his whereabouts.

Static/predisposing factors associated with previous violence

Consider:

- Violence
- Pro-violence attitudes
- Antisocial behaviour
- Relationships
- Employment
- Problematic substance use
- Personality disorder/s
- Other mental disorders (including cognitive impairment, brain injuries, learning disabilities)
- Traumatic experiences
- Treatment adherence and response to treatment

Child and youth also consider:

- Peer group/influences
- School achievement/engagement

Mr Brown reported a brief romantic relationship in his early 20s and that there was an agreeable ending to this, with the pair remaining friends and that immediately following their separation he experienced 'bad' depression for several months (for which he did not seek treatment). He reported coping by smoking cannabis which caused him to 'spaz out and smash up his radio'. After this he decided to curb the smoking to just before bedtime.

At interview for the VRAM, Mr Brown said he had no history of harm to others at any point across his life, outside of the stalking allegations. He confirmed there was only one act of property damage (no known reports to police surrounding this). Mr Brown's brother, Jake confirmed this history.

Jake was aware Mr Brown had been diagnosed with a delusional disorder. He said there was a paternal cousin with schizophrenia but no other family history of mental ill health or violence.

Mr Brown explained that his mother, who Mr Brown was very close to/previously lived with died suddenly due to a heart attack six months prior to the commencement of the stalking allegations.

Outside of these two relationships, Mr Brown described himself as a 'lone wolf', that he drinks alone when he attends the pub once a week and tends to prefer his own company.

Mr Brown commenced smoking cannabis in his late teens and continued to use this regularly prior to bed to 'calm my nerves so I can bloody sleep, you can't take that away from me, I am only using it once per week'. He said since being prescribed olanzapine nocte he had reduced the amount he smokes but still finds he needs 'a little bit' to assist with sleep onset. He 'only drinks' alcohol on pension days once per fortnight as 'it's too expensive' and has 'no more than six pints' of beer. He reported he has never been violent when under the influence of substances.

Mr Brown described his schooling as 'okay' academically with him achieving a Grade 12 certificate. He recounted being bullied regularly over most of his secondary schooling 'as the other kids thought I was different' and 'every now and then' being the victim of physical assaults with one requiring emergency care as his arm was broken. He had a couple of good friends, and they lost touch after they finished school.

Mr Brown said that he had not worked for three years and had longstanding problems with employment as he was 'different to other people' and had always struggled to fit in. There had never been any violence in the workplace and Mr Brown's brother described him as 'having a good work ethic when others will give him a go'. He had some interest in woodwork and had held a job for ten years in this industry and obtained a Cert IV Furniture Design and Manufacturing.

Dynamic factors that precipitated previous violence

Consider:

- Insight
- Violent ideation
- Symptoms of major mental disorder (including cognitive impairment, brain injuries, learning disabilities, and dementia)
- Problematic substance use
- Treatment adherence and response to treatment
- Living situation
- Social situation
- Stress/coping
- Anger
- Impulsivity

Child and youth also consider:

- Peer influence

Mr Brown's recount of the time leading up to and during the alleged stalking suggests that his insight and decision making at the time of the incidents was impacted by his delusional beliefs as he thought he was at risk from his neighbour and that he had to manage this. He was not yet diagnosed with or treated for delusional disorder.

Mr Brown reported that after the sudden passing of his mother he had found it very hard to cope. His cannabis use increased around this time and he continued to use 'a few times a day' up until he was charged. Around this time, he said he had also become more preoccupied by beliefs that the neighbour was out to get him. He felt he had no other means of resolving this but to 'take matters into my own hands' and confront the neighbour.

Mr Brown said he would never have acted on the threats of homicide and made these statements as he felt like he had no other way of stopping this (mis)perceived persecution from the neighbour. His view was that these statements were not made impulsively but rather after much rumination and consideration of how to respond, that this seemed to him to be the best way to manage his distress/fear at the time.

Dynamic factors that contribute to current and future risk of violence, including foreseeable changes that could quickly increase risk state

Consistent with recent file notes, Mr Brown reported at the VRAM interview that he believes the neighbour was previously 'out to get me'. He has been able to ignore these thoughts for several months now, to 'not get caught up on them', and does not believe the neighbour is currently trying to harm him. He has resumed his daily routine, and he is able to go about his day engaging in woodwork, walking for one to two hours after breakfast and watching TV. The thoughts no longer impact on his sleep or eating.

Mr Brown confirmed that he no longer knows the whereabouts of the neighbour as they moved out around the time he was charged. He has not tried to find this person on social media or by any other means. He stated he was told the neighbour likely moved interstate and that he has found this very reassuring as he was very fearful of his former neighbour at one point.

Mr Brown said he has recently had three sessions with a counsellor at the local Non-Government Organisation (NGO) to process grief/loss related to the sudden passing of his mother. He also mentioned utilising sensory strategies including walking daily, fidgets and weighted blankets with good effect when he is having any anxiety.

Mr Brown continues to use substances and reported this was to help him cope with 'bad stuff from school' and 'mum'. He intends to explore this with his case manager and counsellor.

While there were no foreseeable changes identified by Mr Brown, the treating team flagged that his case manager will be going on Maternity leave in the next few months. His case manager has developed a strong therapeutic rapport, engaging with discussion on his interests, e.g. woodwork and boardgames.

Specific inpatient dynamic risk factors

Consider:

- Confused/over-excited behaviour
- Irritable/sensitive to provocation
- Physically/verbally threatening/property damage
- Impulsivity
- Unwilling to follow directions/angered when requests are denied

Mr Brown was managed in the community.

Protective factors and strengths

Consider:

- Treatment adherence and response to treatment
- Coping/social skills
- Stable living situation
- Stable mental/emotional state
- Relationships/supports
- Available resources (readily accessible)
- Insight/awareness of triggers
- Meaningful time use

Child and youth also consider:

- Peer relationships, supports and activities

- Motivated for referrals to support worker to assist him to link with Men's Shed to do woodwork.
- Does not know where the neighbour moved to.
- He has been able to ignore thoughts about the neighbour.
- Resumed daily activities, including daily walks and neurovegetative symptoms have improved.
- Linkage with NGO counsellor to process grief/loss.
- Some support from brother (who lives interstate).
- One friend (previous partner) who he sees occasionally for boardgames and who he communicates with via texts a few times a week.
- Previously held a job for 10 years.
- Cert IV and interest in woodwork.

Violence risk summary

Consider risk status (relative to others in a stated population) and risk state (relative to self at baseline or during previous significant periods) informed by static and dynamic factors:

- Specific population needs (e.g. general population, community settings, inpatient settings)
- Probable nature and imminence of future violence
- Most likely targets of violence (victims)
- Factors that mitigate risk
- Factors that could increase risk
- Potential high risk scenarios

Presenting problem

Mr Brown has outstanding charges of 1 x unlawful **stalking** uses/threatens violence of their former neighbour occurring from July 2025 to October 2025. While there has been no contact with this person since they moved in October 2025, the duration and frequency of unwanted contact and threats towards the former neighbour are of concern, escalating from 'nuisance' behaviours (playing music loudly) to yelling profanities, throwing rocks, and threats of harm (including threatening to 'burn' the neighbour while burning rubbish, and threats to kill).

Predisposing factors

Mr Brown had one previous episode of **property damage** in which he smashed a radio in his early 20s in the context of a relationship break up, increased cannabis use and untreated depression. Since then, he has had limited social supports, frequent changes in accommodation, and periods of unemployment. In high school, Mr Brown was a victim of bullying and physical assaults in high school (one resulting in a broken arm). Mr Brown did not receive mental health input/treatment until July 2025 for a recent diagnosis of delusional disorder. Mr Brown's forensic history includes: 2 x Possessing dangerous drug, p*ossess utensils or pipes, fail to appear and breach of bail due to not residing as directed/approved.* He has used cannabis and alcohol to cope with symptoms (?trauma) since his late teens.

Precipitating factors

Mr Brown's mother, his key support whom he lived with, died suddenly from a heart attack in early 2025; he now lives alone and is largely solitary, being unemployed and having minimal social contact. He has coped poorly with grief/loss and has increased his use of cannabis to three times per day. This reflects a similar pattern to the loss of a relationship in his 20s which precipitated property damage. Since the sudden loss of his mother, Mr Brown's mental state deteriorated, featuring fear and distress followed by increased preoccupation with delusional beliefs that the neighbour was 'a sicko' and was going to harm him. His insight and judgement appear to have been impacted by his delusional beliefs, demonstrated by escalating threatening behaviours. Mr Brown ruminated on feelings of persecution and felt he had no other means of problem solving this but to 'take matters into my own hands' to manage his distress/fear at the time.

Perpetuating factors

While Mr Brown does not believe that his ex-neighbour is currently trying to harm him, he has ongoing problems with insight and continues to believe the neighbour was 'out to get him'. He continues to use cannabis and alcohol as a coping mechanism, particularly to assist with poor sleep. His ongoing isolation and limited coping skills make him vulnerable to engaging in ruminative thoughts and may maintain his difficulty dealing with challenges presented by other people.

Protective factors

Despite limited insight into the problems with his stalking behaviours, Mr Brown is motivated to receive support for his mental health, recognising that it impacts on his day-to-day functioning. His neurovegetative symptoms have improved with treatment, and he is benefiting from counselling with and NGO to address his grief and loss. He has resumed a daily routine and activities (e.g. daily walks) and is keen for assistance to link with the Men's Shed to do woodwork (for which he holds a qualification). Daily occupation and social connection may alleviate isolation and reduce opportunities for rumination. Importantly, Mr Brown does not know where the neighbour moved to and has been able to ignore thoughts about the neighbour. Mr Brown has some support from his brother Jake (who lives interstate) and a friend with whom he plays boardgames.

High risk scenarios

A high risk scenario may involve the loss of key supports in his life (e.g. case manager going on leave, loss of his female friendship), which leads to feelings of isolation and stress, increased cannabis use and mental state deterioration characterised by delusional beliefs about a specific person's sexuality and that he is at risk of harm from this person together with associated feelings of distress and fear.

Early warning signs (for violence)

- Increased use of cannabis to cope with stressors.
- Increased preoccupation with delusional themes of persecution.
- Feeling overwhelmed/that there are no alternative ways to cope.
- Making statements that others are 'sickos' or 'weirdos'.

Foreseeable changes

- His case manager (with whom there is a strong therapeutic alliance) going on leave in next few months.
- Outstanding court matters/future court dates.

Victim group

- Mr Brown's former neighbour (unlikely to cross paths again).
- People incorporated into his delusional beliefs that he falsely believes are a threat to him.

Probable nature of future violence

Given the types of previous harm, Mr Brown is most likely at risk of **property damage** (e.g. smashed radio), alleged **stalking type behaviours** (unwanted contacts) and **homicidal threats** as well as **setting fires** to intimidate others. During the episode of violence there was some escalation with his behaviours progressing from unwanted contacts to homicidal threats to lighting fires. Protectively he has not engaged in these behaviours since care and treatment commenced.

Imminence of future violence

While Mr Brown's risk of violence is elevated across the longer term there were no indicators that he was at imminent risk of further stalking or threats of homicide. This may change suddenly in the context of a deterioration in mental state, non-adherence with treatment and/or increased use of substances.

Risk status

Mr Brown's risk of violence across time is higher than others typically seen in the community mental health service given his forensic history, allegations of stalking/threats of homicide, previous property damage, diagnosis/manifestation of symptoms, ongoing beliefs that he was persecuted in the past by the alleged victim and that he continues to use cannabis each night.

Risk state

Mr Brown's risk state is lower than when he was charged in October 2025 given his mental state has improved, he no longer believes he is actively being persecuted/although does continue to hold a delusional memory of this, is engaging in treatment by way of depot, does not know the whereabouts of the alleged victim and that his problem-solving/judgement has improved (e.g. he was not planning to locate or contact the neighbour). Mr Brown is now managed under a Treatment Authority, has engaged well with his case manager, is seeing a counsellor to expand coping skills and has decreased his cannabis use.

Prevention oriented risk management plan

Identify what actions are required for **each** dynamic risk and protective factor, including safety planning with the consumer/carer/family/support networks/potential victims.
Risk management strategies must be incorporated into the consumer Care Plan.

Risk increasing factor	Clinical goal	Preventative strategies, interventions and involvement of other service providers
Charges for stalking/ homicidal threats.	To reduce risk to future victims.	• Ongoing case management under a TA by a person who has developed good rapport with Mr Brown. • Serial MSE and risk screen reviews fortnightly to monitor for deterioration in mental state e.g. incorporation of others (potential future victims or increased preoccupation with past victim). • Liaise with the Court Liaison Service to establish court dates. • Closely monitor foreseeable changes (e.g. Court dates, changes in PSP) and increase risk screening frequency in the lead up to and post court and to changes to his case manager. Ensure he is linked with a new case manager who is able to develop a good rapport (link to his interests in woodwork and boardgames) and that this transition starts ahead of planned maternity leave with cross over between the old/new PSP to enable time to start to build a therapeutic alliance. Consider similar process for any future changes in case management. • Maintain Alerts on CIMHA and ieMR. • Develop a Police Advice and Intervention Plan (PAIP) with the support of the Mental Health Intervention Coordinator (MHIC). • For Assessment and Risk Management Committee (ARMC) review post VRAM and further review after 6 months.

Delusional beliefs/insight.	To manage symptoms/reduce risk.	• For ongoing case management under a TA. • Continue assertive treatment with depot. • Monthly medical reviews to monitor treatment. • Continue to have serial MSE and risk screen reviews fortnightly. • Psychoeducation around early warning signs, triggers, precipitating factors and develop a plan for relapse (utilise this information to create a person-centred Acute Management Plan (AMP)). • Problem solving work to support him to identify alternative ways to cope/who to reach out to and how.
Stress/coping.	To enhance coping skills.	• Ongoing monitoring and supportive problem solving by PSP. • Linked with private counsellor via NGO for grief and loss. • Encourage use of sensory approaches in situations that increase anxiety. • With consent, PSP to continue communication with NGO to enable consistent approaches with building/supporting coping skills.
Cannabis and alcohol use.	To reduce harms associated with use.	• PSP to utilise motivational interviewing and trauma informed frameworks to work with Mr Brown to provide psychoeducation and identify goals around his substance use. • Sleep hygiene sessions and interventions as well as medical review of biological treatments for sleep. • Consider sensory strategies/AOD tool around this (Insight - Resources - Using Your Senses to Cope - Sensory tool for clients) given previous good effect from sensory approaches. • Ongoing monitoring via self-report and urine drug screening (UDS) only if indicated.
Protective factors	**Clinical goal**	**Preventive strategies, interventions and involvement of other service providers**
Cert IV and interest in woodwork.	Meaningful use of time.	• Motivated to be referred by PSP to a support worker to assist him to link with Men's Shed to do woodwork. • Monitor and assist with problem solving any future barriers.
Insight around grief/coping responses.	Enhance coping skills.	• Engaging with an NGO counsellor to process grief/loss. • PSP to continue to monitor progress and regularly consult with (consent has been provided) the counsellor so that there can be consistent strategies/approaches to this and Mr Brown's PAIP and AMP can be updated accordingly.
Support from brother and friend.	Maintain personal supports.	• Continued psychoeducation with brother. • Consider social skills training (with agreement from Mr Brown) to assist him to maintain social supports and to make new connections at Men's Shed. • Monitor linkage with supports/assist with social problem solving.

This assessment is informed by (note engagement with consumer, and sources of collateral)

- A selected review of Queensland Health databases (CIMHA and The Viewer).
- An interview with Mr Brown on XX/XX/XX, for a period of 85 minutes.
- Discussions with Mr Brown's treating Consultant Psychiatrist, and the Forensic Liaison Officer (FLO).
- A phone call on XX/XX/XX for 35 minutes with Jake Brown, Mr Brown's brother (with informed consent being obtained from both parties).
- A phone discussion with the Queensland Health Victim Support Service (QHVSS) who are supporting the alleged victim for Mental Health Court on XX/XX/XX.
- Queensland Police Court Brief (QP9) documentation and forensic history.
- Minutes of Assessment and Risk Management Committee (ARMC) meeting on XX/XX/XX.

Information provided to consumer/carer/family/support persons (detail the information provided to the consumer/carer/family/support networks regarding this risk assessment and management plan. Where applicable include obligations under the *Mental Health Act 2016*. Note the consumer/carer/family/support networks understanding of the assessment, risk management plan and clinical goals)

- Informed consent and basic psychoeducation provided to Mr Brown during VRAM interview.
- Psychoeducation briefly provided to brother during collateral gathering. PSP to follow up at next contact.