QC30 Violence Risk Assessment and Management

Participant Workbook

Version control

Version	Date released	Changes	Authorised by
1.0	22 July 2026	Redeveloped as part of the workshop review.	Irene Francisco
1.1	14 August 2026	Minor edits after Train the Trainer.	Irene Francisco

Contents

Course introduction

Overview	This workshop has been designed to provide learners with practice in completing a comprehensive, individualised Tier 2 Violence Risk Assessment and Management tool (VRAM) with focus on the three following components: • information gathering for violence risk • developing a violence risk summary (formulation) • prevention oriented violence risk management planning. It has been designed to support learners' working knowledge of the Assessing and Responding to Violence (ARV) Framework by examining a range of contexts and factors that indicate the need for escalation through the framework's three tiers.

Background	Originally developed in 2018, QC30 Violence Risk Assessment and Management aims to support clinicians' knowledge and application of the three-tiered approach to violence risk assessment and management within the Mental Health and Other Drug Services Assessing and Responding to Violence (ARV) Framework. This current version is a result of the most recent review in 2026. Whilst the main structure and flow is similar, there have been some alterations to content to: • ensure alignment to updated frameworks, policy and guidelines • embed trauma informed language and principles • strengthen cultural capability • strengthen alignment with domestic and family violence frameworks, including victim safety planning. At the time of publication, all course components have been updated to align with current frameworks, policies and guidelines. It is acknowledged this is an ongoing process and the Learning Centre will continue to follow a rigorous quality assurance process to ensure all training is updated in line with new policies and guidelines.

Anticipated learning outcomes	The workshop aims to equip learners with the knowledge and skills to: • identify information that is relevant to a Tier 2 Violence Risk Assessment and Management tool (VRAM) • synthesise information to create a violence-specific risk summary (formulation) • determine clinical goals and strategies to mitigate violence risk and strengthen protective factors • explore escalation within the Assessing and Responding to Violence (ARV) Framework.

Start and finish times	8:30am – 4:30pm (including breaks) for face-to-face workshop. If you are attending the workshop in the **online classroom**, the usual times are 8:30am to 12:30pm for both sessions, though some workshops may have variations to times which will be communicated through the Learning Management System.

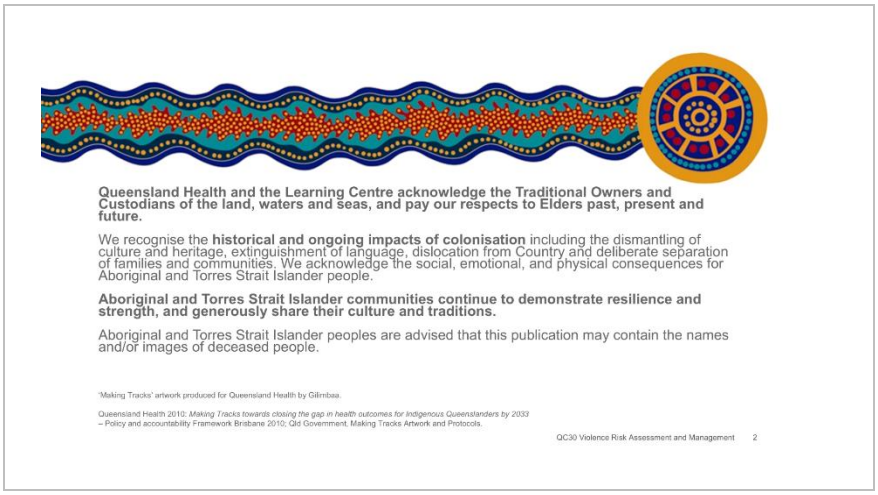
Scope of practice	As guided by the Assessing and Responding to Violence (ARV) Framework, the knowledge and skills acquired during the workshop are designed to be applied by an experienced clinician at the Tier 2 level. To support attendance of experienced clinicians whose scope of practice includes conducting VRAM tools, a short screening questionnaire must be completed by learners prior to any confirmation of enrolment. **It is the learner's responsibility to understand and work within their scope of practice.**

Evaluation strategy	The course is evaluated at three points, before enrolment, post workshop, and 3 months after attending. Participants receive emails containing links to the evaluations, which are automatically sent from the Learning Centre Learning Management System (LMS). Evaluation feedback received from learners (as well as educators) on all aspects of training content, delivery, and processes is recorded and progressed through the quality improvement system.

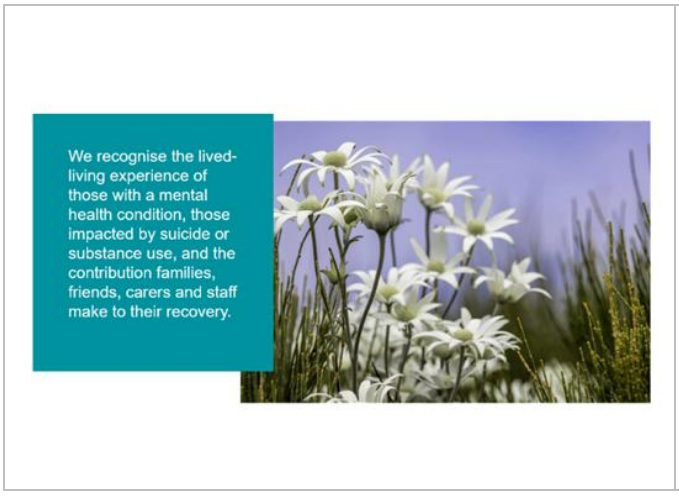
Acknowledgement and thank you	The Learning Centre acknowledges the generosity of those who have provided their expertise, insights, practice wisdom, and lived experience in guiding and shaping the content and design of this course.

Slide 1: Opening slide

Slide 2: Acknowledgement

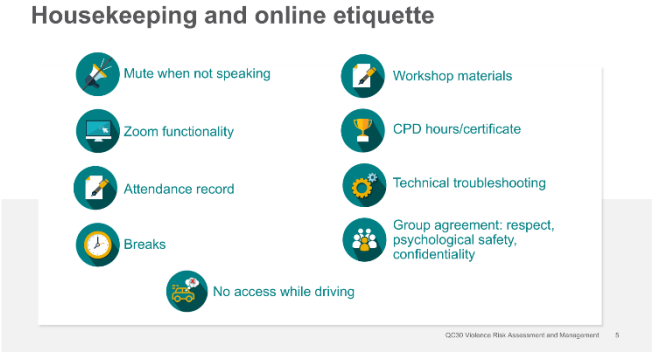


Slide 3: Recognition of lived-living experience and child safety commitment



Slide 4: Introductions

Slides 5 and 6: Housekeeping and online etiquette



Slide 7: Learning outcomes

You will:

- identify information that is relevant to a Tier 2 Violence Risk Assessment and Management tool (VRAM)
- synthesise information to create a violence-specific risk summary (formulation)
- determine clinical goals and strategies to mitigate violence risk and strengthen protective factors
- explore escalation within the Assessing and Responding to Violence (ARV) Framework.

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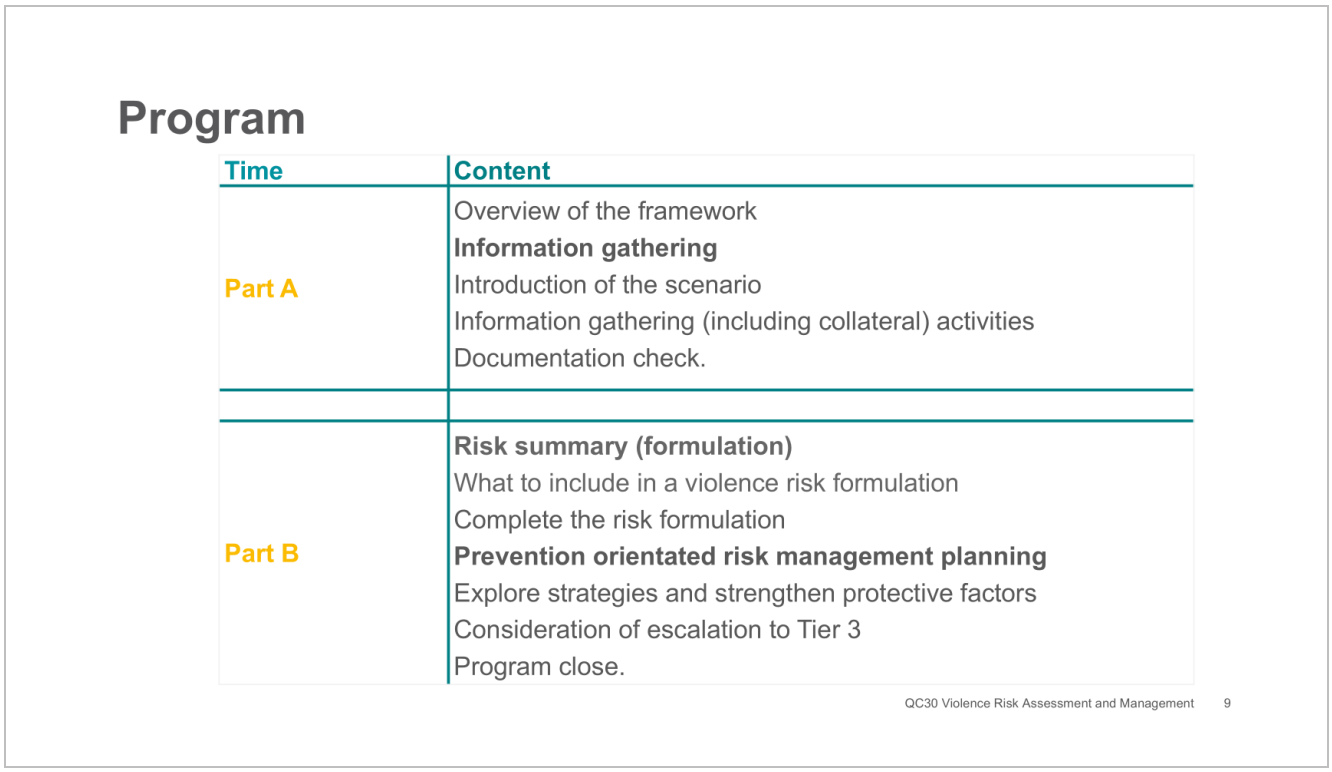
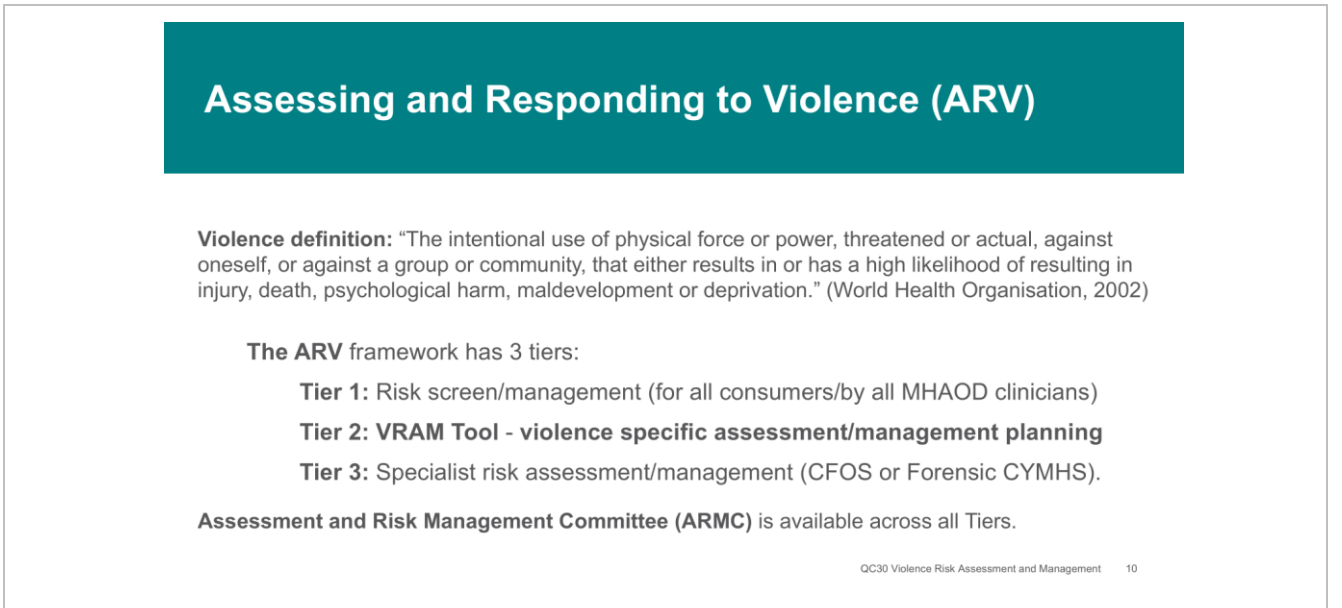
Slides 8, 29 and 35: Slido

When it is time, scan the QR code for Slido.	

Slide 9: Program

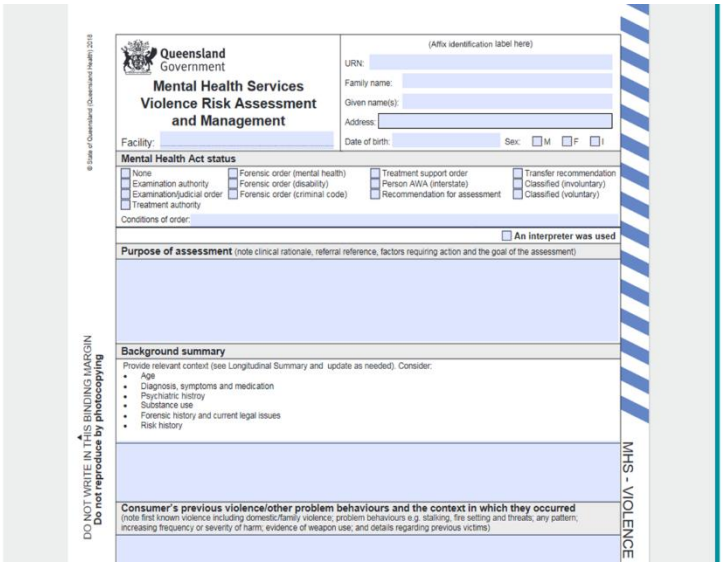


Slide 10: Assessing and responding to violence (ARV)



Notes:

Slide 11: VRAM tool



VRAM tool

11

Notes:

Slide 12: Information gathering

Notes:

Slide 13: Case scenario introduction – Peter or Luke

Slide 14: Let's start together

Peter MDT review note

Queensland Government Mental Health Alcohol and Other Drugs Services **Progress Note** Facility: INPATIENT UNIT	URN: X Family name: X Given names: **Peter** Date of birth: 40 y/o Sex: M

Multidisciplinary Team (MDT) review:

Peter has been an inpatient for 3 days. Diagnosed with schizophrenia. Now under a Treatment Authority (TA). Currently taking oral meds. ?Medication adherence long term.

Living with sister (Rebecca) before coming to hospital. Peter incorporated Rebecca's boyfriend (Steve) into his paranoid beliefs saying Steve would hurt Rebecca. Peter reportedly took a knife from the kitchen into his bedroom prior to admission. Sister said Steve was not harming her.

Mostly settled, apart from appearing angry when he talks about Steve. Keeps to himself on the ward. Does not say much, sometimes asks to call police to report 'Steve' as 'Steve's a bad guy, you don't even know how bad'.

Seen responding to non-apparent stimuli. Some talk of 'the Illuminati' to the nursing staff.

Food intake reasonable, good fluid intake. Needs to be reminded to shower, change clothes.

Urine Drug Screen (UDS) negative.

Sister (Rebecca) and parents have called ward to speak with Peter.

Peter provided written consent to contact Rebecca.

Sister wants to visit ward with Steve tomorrow.

Team discussion:

Active symptoms of psychosis centring around Steve. Nil others incorporated at this stage. Depot written up for today for med adherence – Risperdal Consta 25mg fortnightly due to good tolerance of risperidone previously. Increase dose pending tolerance.

Peter has been told that he is having depot. He said he does not need it, but he won't fight staff if they really want him to have it.

Risk Screen elevated for violence. History of violence, recent attack on uncle, recently hiding weapons.

Nil other risks identified.

Plan:

Consider depot given concerns about compliance after discharge.

No leave.

Refer for a V-RAM due to heightened risk screen.

First signed by:	Discipline:	Date:	Time:
TRAINING, Clinician	RN	XX/XX/XX	XX:XX

Luke MDT review note

Queensland Government Mental Health Alcohol and Other Drugs Services **Progress Note** Facility: COMMUNITY CYMHS	URN: X Family name: X Given names: **Luke** Date of birth: 16 y/o Sex: M

Multidisciplinary Team (MDT) review

Luke was recently referred to CYMHS by the Guidance Officer (GO) (currently in year 12) due to concerns about anxiety, difficulty demonstrating empathic responses and behavioural difficulties i.e. increasing aggression towards students.

Current diagnosis: F43.1 post traumatic stress disorder.

Background

History of reactive violence and aggression towards mother and sister warranting accommodation change. Violence and aggression occurred in the context of limit setting and high levels of anxiety with Luke managing this by using aggression to control the environment.

Challenging behaviours/violence in the home led Luke's mother to send him to live with his maternal uncle for 6 months. While at his Uncle's place, Luke was reportedly exposed to illicit substance use (witnessing and occasionally partaking) and suspected trauma/abuse (demonstrated hypervigilance and nightmares since).

In the six months since returning from his Uncle's, there has been an escalation in frequency and severity of aggression and violence at school and at home. Recent serious, pre-planned physical assault on a fellow student at school fueled by a grievance from an incident that occurred two days prior. Luke is currently suspended. School considering exclusion.

Other relevant information: disrupted attachment, difficulty making friends and poor interactions with peers from a young age, a lack of remorse, communication difficulties, emergence of attitudes supporting use of violence (e.g. Luke said he was willing to defend himself from others using physical force if required) and leaving school grounds without permission, interrupting class, bullying others. Nil psychotic symptoms. Luke engaged with CYMHS.

Recommendation

- Psychiatric review.
- Further develop safety plan regarding mother and sister (Mother has agreed to call police if there are any concerns for her or daughter's safety).
- Administer VRAM to identify risk factors for ongoing long-term violence at school and towards family. Identify protective factors which maintain stability for Luke and family.
- Team Leader to allocate VRAM to senior clinician.

First signed by:	Discipline:	Date:	Time:
TRAINING, Clinician	Psychologist	XX/XX/XX	XX:XX

Queensland Government

Comprehensive Assessment

URN:

Family name:

Given name(s): **Peter**

Address:

Ph (H):

Ph (M):

Sex: Male

Date of birth:

Treatment Status

Mental Health Act 2016 status:	**Treatment Authority**
Conditions of MHA order:	**Inpatient category**
Other status:	Nil.

Substitute decision maker

Substitute decision maker:	None
Advance Health Directive:	None
Enduring Power of Attorney:	None
Guardian:	None
Administrator:	None

Reason for referral

NB: Clinical documentation would usually include just the specific dates. For training purposes we have added timeframes to aid orientation.

Peter is a 40 y/o male who attended the Emergency Department (ED) with his sister Rebecca on XX/XX/20XX (yesterday), due to her concerns about his mental health, him acting strangely and her being worried about risk to others.

Last contact with Mental Health Service (MHS) in QLD was 6 years ago - diagnosis of schizophrenia/drug induced psychosis, and substance use disorder.

Seen in ED briefly by Sam, MHS Clinical Nurse Consultant (CNC). Peter was experiencing symptoms of psychosis and requesting to leave the hospital, resulting in a Recommendation for Assessment being made.

History of presenting problems

Information from Rebecca:

Peter moved into Rebecca's house approximately 1 month ago after living in Sydney with their parents. Peter had moved out of his parents' house after he punched his uncle Tim repeatedly in the head.

In the lead up to Peter coming to ED, he was acting out of character and "saying strange things to Steve" (Rebecca's boyfriend). Rebecca and Steve found this disturbing and described it as "menacing". They noticed that kitchen knives went missing from the kitchen and later found them in Peter's room when he was out.

Health related history including physical, mental health, and alcohol and other drugs

Health related history

Mental Health History

File Review:

Peter reported first "hearing from" the Illuminati around age 19. This was consistent with information from his parents who have described him as responding to non-apparent stimuli in the absence of substance use when he was 19. Peter began drinking alcohol when he was 17 and came home drunk on several occasions. He began using cannabis in high school. Previously used amphetamines to 'help stay awake' with intermittent use commencing around age 21.

Queensland Government

Comprehensive Assessment

URN:

Family name:

Given name(s): Peter

Address:

Ph (H):

Ph (M):

Date of birth: Sex: Male

After his second year of university, Peter was drinking heavily and going out 'a lot'. He failed some university subjects and lost his job. By around the age of 20 years, his parents saw him talking to himself on several occasions. After this, Peter ceased using alcohol and began working in hospitality.

When Peter was around 21 or 22, he moved in with Rebecca. He got a job in a local restaurant in the nightclub district and made friends through work. His sleep patterns were strange due to his work hours and Peter complained of being tired most of the time.

Around this time, he started using amphetamines at work. He 'liked the buzz' and energy burst that he got. Rebecca rarely saw Peter due to their work shifts. She noticed bruises on his hands and face and asked him if he had been fighting. Peter said that he was in a couple of "scrapes" in pubs but nothing serious. When Rebecca did see Peter, she would noticed strange things, like Peter talking to himself in his room and being distracted during conversation.

First contact with QLD Mental Health Alcohol and Other Drug Service (MHAODS) was 6 years ago when admitted. At this time a check of NSW records showed no mental health history in NSW prior.

First Admission:
Six years ago, Peter was referred to the ward as a voluntary patient via ED after he was brought in by (BIB) police as he had accused a police officer of being a paedophile and punched him in the chest.

At ED Peter was grandiose, circumstantial and reported auditory hallucinations. He stated that "the Illuminati" told him that the police officer was going to assault a child, and it was his job to ensure the police officer didn't do this. He reported that the Illuminati talked to him constantly, telling him "who was good and who was evil", that he had secret powers and a "super high" intellect. He would not discuss his missions as these were "top secret". There was some paranoia that he was being watched through electronic devices.

At this time a urine drug screen (UDS) was positive for cannabinoids and amphetamine. Peter had also been drinking alcohol prior to coming into ED. He was admitted for diagnostic clarification and stabilisation of his mental state.

Peter confirmed during this admission that he had been having auditory hallucinations on and off for about 15 years and had them in the absence of substance use.

A Mental State Exam (MSE) during this previous admission noted that he had restricted affect, some guardedness. He reported the Illuminati were still talking to him (not as loud or as often). Ongoing grandiose delusions about having "a special purpose", something which mental health staff would not understand and beliefs that the Illuminati picked him for a reason. Not suicidal. No passivity phenomena. Felt safe in hospital, no one out to harm him. No thoughts of harming others. Judgement was slightly impaired. Insight: thoughts were clearer, although did not think he had psychosis. He said that risperidone improved his thoughts and was willing to continue taking it.

Peter was adherent with medication on the ward, there were "no issues", he was conversational with others, grandiose and intrusive at times but responded well to redirection. He was treated with risperidone 1mg BD with good effect and eventually discharged to the continuing care team.

Described as polite and co-operative upon community follow up. He moved to Sydney to live with his parents without informing his treating team about 6 months after being discharged from hospital.

End of Episode: Diagnosis of schizophrenia/drug induced psychosis, and substance use disorder was recorded.

Queensland Government

Comprehensive Assessment

URN:
Family name:
Given name(s): Peter
Address:
Ph (H):
Ph (M):
Date of birth: Sex: Male

Alcohol and other Drugs (AOD):

File Review: Peter reported monthly use of cannabis and weekly use of alcohol and amphetamines prior to the admission 6 years ago. He was contemplative of ceasing amphetamines, blaming them for him hitting the police officer, and said he needed to cut down. He declined a referral to an AOD service at the time.

Currently: No gambling. Not intoxicated or withdrawing currently. Peter reported using Valium and Xanax without a script - approximately once per week.

Physical Health:
Peter requires metabolic monitoring. For physical review. No medical conditions noted on ieMR.
File notes from first admission 6 years ago indicate: “Good food intake. No overt signs of physical health issues. Blood screens done - no abnormality detected”.

Previous medications:
20XX – risperidone, duration: ?6 months, 1mg BD, prescribed by inpatient psychiatrist during first admission 6 years ago.

Current medications:
Nil known.

Encounter History

XX/XX/20XX - MH IPU
XX/XX/20XX - WM Awaiting Intake Review
XX/XX/20XX - MH COM
XX/XX/20XX - MH IPU

Date substance use and addictive behaviours screen completed: Not completed

***Instruction: Note current and past use patterns including frequency, quantity and route of administration, dependence, withdrawal, triggers for use etc for each substance.**

☐ Information unavailable at this time ☐ Not applicable to this consumer/presentation

Tobacco products substance involvement score: 0

No intervention

Alcoholic beverages substance involvement score: 5

No intervention

Cannabis substance involvement score: 3

No intervention

Queensland Government

Comprehensive Assessment

URN:
Family name:
Given name(s): Peter
Address:
Ph (H):
Ph (M):
Date of birth: Sex: Male

Cocaine substance involvement score: 0

No intervention

Amphetamine type stimulants substance involvement score: 0

No intervention

Inhalants substance involvement score: 0

No intervention

Sedatives or sleeping pills substance involvement score: 7

Receive Brief Intervention

Hallucinogens substance involvement score: 0

No intervention

Opioids substance involvement score: 0

No intervention

Other substance involvement score: 0

No intervention

Medications

Medications Ceased

Generic Name (Brand) Strength Form	Status	Reason
risperidone (*Brand*) 1mg PO BD	?6 months	?self-ceased

Forensic history and current legal issues

☐ Information unavailable at this time ☐ Not applicable to this consumer/presentation

Currently:
Peter reported that he has never been charged. He asked if staff could call the police so he could talk to them about Rebecca's boyfriend, Steve. Altercation with police officer, approx. 6 years ago. Peter said he does not have access to a gun.

Queensland Government

Comprehensive Assessment

URN:
Family name:
Given name(s): Peter
Address:
Ph (H):
Ph (M):
Date of birth: Sex: Male

File notes from 6 years ago outline that he had:
• No criminal history.
• No outstanding charges despite the police taking him to ED. On this occasion police acknowledged to the clinician that his violence against the police officer was likely driven by mental health issues rather than criminal intent; and that charges would likely be thrown out.
• Reported he had been in occasional pub fights during his 20s while intoxicated with alcohol. No serious injuries to himself or the other person. The fights were started by Peter when "people are talking rubbish". He said he usually went for "one good hit" then stopped. He intended for the punch to teach victims a lesson, and to "get them to shut up". After this Peter did not feel the need to continue the fight. Peter confirmed he was not being treated for "the voices" he was also experiencing around this time.

Family history

☐ Information unavailable at this time ☐ Not applicable to this consumer/presentation

No reported family history of mental health problems, disability or physical health concerns. No history of his family members using violence/police charges.

Peter is youngest of 2 siblings. Rebecca is 4 years his senior. Peter has a great relationship with his parents who he usually talks to regularly.

Father works as a surveyor for the local council and mother works in administration.

Rebecca is a paediatric nurse working locally. All family members get along well, with the exception of Peter and his uncle Tim. Rebecca described uncle Tim as sometimes being abrupt or rude, but he was never abusive or violent.

Developmental history

☐ Information unavailable at this time ☐ Not applicable to this consumer/presentation

File notes and discussion with Rebecca:

- Nil developmental delays or issues.
- Peter grew up in Sydney where he was suspended from high school in grade 10 for smoking cigarettes on school grounds.
- After grade 10 Peter began using alcohol and his friendships tended to revolve around alcohol use.
- This behaviour followed him being sexually assaulted by a male teacher during a 1:1 lunchtime detention with the teacher in grade 10. Peter never told anyone at the time and his family remain unaware. Peter has only disclosed this once during his previous admission and according to file notes he requested to "never discuss it again".
- Despite the traumatic event at school, Peter maintained friendships and completed high school achieving average to above average grades.
- Rebecca has described Peter as always reading about "odd things" in his teens such as the occult, ancient mythology and ancient religions. This interest continued into his adulthood.
- Peter worked at a fast-food chain during high school for 2 years and then left during grade 12 when he was studying for his final exams.
- Went to university, studied engineering.
- Peter had a girlfriend who he met at university and was in a relationship with her for approximately 4 months.
- After his second year of university, Peter got an internship with a draftsperson at a local engineering firm. Around this time he started drinking heavily and going out more often with the other interns. He struggled to meet his university deadlines and failed two subjects. He also became withdrawn and haggard looking. He was secretive with his family and would stay up all night. His family saw him talking to himself on several occasions. Peter lost his internship and left university.

Queensland Government

Comprehensive Assessment

URN:
Family name:
Given name(s): Peter
Address:
Ph (H):
Ph (M):
Date of birth: Sex: Male

- Peter's parents paid for him to complete a course in hospitality, and he became more social and interactive after he dropped out of university. He stopped drinking.
- Peter has had a few periods of unemployment. However, he typically works and moves between employers every 9 – 12 months. Generally, works in hospitality e.g. cafes.
- Reported having friends through work 6 years ago.

Psychosocial functioning

☐ Consumer requires a functional assessment ☐ Consumer requires a cognitive assessment

File review:
In the past Peter has managed his own finances and is independent in terms of activities of daily living (ADLs).

Current concerns:
Accommodation Issues – uncertainty about whether Peter will be able to continue living with Rebecca and Steve. Rebecca said he used to be able to function independently but recently she has been concerned about this in a setting of mental state deterioration.

Mental state examination

- **Appearance and behaviour:** Peter was a tall solid man who looked older than his age. He was dishevelled and unkempt, close-cropped hair. He wore casual clothes which were observed to be stained. He was agitated in the interview, pacing the floor and checking that Rebecca was in the waiting room. Sat down when asked to do so. Stared intently at the assessor during the assessment.
- **Speech:** normal in rate, volume and tone.
- **Mood and affect:** Peter described his mood as 'worried' and that he could not settle due to the bad people he saw. His affect was blunted with some reactivity.
- **Perceptual disturbance:** auditory hallucinations of a range of voices (maybe five voices), all male, of the Illuminati. The voices were all people he did not know. No other perceptual disturbances.
- **Thought form:** racing thoughts, tangential responses to questions, frequently returned to discussing Illuminati and Steve.
- **Thought content:** he reported he was safe at work as the people there are all 'good in their cores'. He occasionally sees someone in public who he knows to be 'evil' or 'bad' and he avoids them. Peter knew Steve was bad due to messages he was getting from the Illuminati.
- **Judgement:** was impacted by his insistence that Steve was a 'bad guy' despite evidence to the contrary, and due to behaviours i.e. the secreting of knives at home.
- **Insight:** he thought his major issue was racing thoughts, but did not think he had a psychotic illness or any other mental health disorder. He did not want any ongoing mental health involvement. He said he would take oral medications in the short term to slow his mind down but saw no need to take them long term.
- **Cognition:** orientated to time, place and person. No overt issues with memory.

Queensland Government

Comprehensive Assessment

URN:

Family name:

Given name(s): Peter

Address:

Ph (H):

Ph (M):

Date of birth: Sex: Male

Risk screen Y=yes N=no UK=unknown

Suicide

Static factors	Y	N	UK
Previous attempt	☐	☑	☐
Previous self-harm	☐	☑	☐
Exposure to suicide	☐	☐	☑
Stressful life events (mental disorder, physical illness/pain, unemployment, history of trauma, homelessness)	☑	☐	☐

Dynamic factors	Y	N	UK
Suicidal thoughts	☐	☑	☐
Plan (consider detail of plan and access to means)	☐	☑	☐
Loss of hope	☐	☑	☐
Lack of social support	☐	☑	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:

- Nil known suicide attempts or self-harm or exposure.
- Stressful life events: mental health, periods of unemployment, relocations interstate, conflict with Uncle Tim, police attention.

Dynamic:

- Nil reports of suicidal thoughts or plans.
- Nil hopelessness expressed. Future oriented and is hopeful he 'will patch things up with Rebecca'.

Foreseeable:

- Lack of social support/future stressors: A potential destabiliser relates to accommodation. Peter cannot live with Rebecca and accommodation will need to be sourced.

Violence/aggression

Static factors (history of)	Y	N	UK
Violent/aggressive behaviour	☑	☐	☐
Sexually inappropriate behaviour	☐	☑	☐
Domestic/family violence	☑	☐	☐
Criminal charges	☐	☑	☐
Problematic substance use	☑	☐	☐
Personality disorder/s	☐	☑	☐
Other mental disorder/s	☑	☐	☐
Other problematic behaviour (e.g. fire setting, stalking, threats)	☑	☐	☐

Dynamic factors	Y	N	UK
Anger	☐	☐	☑
Impulsivity	☐	☐	☑
Problematic substance use	☑	☐	☐
Problematic treatment adherence	☑	☐	☐
Violent ideation	☑	☐	☐
Pro-violence attitudes	☐	☐	☑
Symptoms of psychosis	☑	☐	☐
Carries weapon/**access to firearm***	☑	☐	☐
Exhibits bullying behaviour	☐	☐	☑

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:

History of violence:

- Early 20s:
  - Fights in pubs while intoxicated with people he found annoying to get them to "shut up" or "teach them a lesson"
  - Reported that no one was significantly hurt and was not charged.

- Peter confirmed he was not being treated for “the voices” at this time.

- Assaulted (punched) police officer around 6 years ago whilst intoxicated. Believed officer was going to harm children.
- About one month ago he punched his uncle Tim several times while delusional.
- Recent targeted anger towards Rebecca's boyfriend Steve with threats to shoot him in the context of Steve being incorporated into Peter's delusions.

Dynamic:

- Symptoms incorporating an identified target: Recent targeted anger towards Rebecca's boyfriend Steve with threats to shoot him in the context of Steve being incorporated into Peter's delusions: Peter knew Steve was “bad” due to messages he was getting from the Illuminati.
- Peter’s judgement appears impacted by his beliefs e.g. insistence that Steve was a ‘bad guy’ despite evidence to the contrary, and behaviours i.e. hiding large kitchen knives at his sister’s house.

Foreseeable:

- Discharge/accommodation issues, reduction in support from Rebecca.

*Consider the need to notify the Weapons Licensing Branch

Vulnerability

Static factors (history of)	Y	N	UK
Trauma/abuse	☐	☑	☐
Domestic/family violence	☑	☐	☐
Financial vulnerability	☐	☑	☐
Cognitive impairment/disability	☐	☑	☐
Lack of family support	☐	☑	☐
Blood borne virus	☐	☑	☐

Dynamic factors	Y	N	UK
Impaired decision making	☑	☐	☐
Sexually disinhibited	☐	☑	☐
Self neglect	☑	☐	☐
At risk of victimisation (incl sexual)	☐	☑	☐
Impaired interpersonal boundaries	☐	☑	☐
Pregnant	☐	☑	☐
Recently incarcerated	☐	☑	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:

- Peter’s sister says he can usually look after his own money and prepare his own meals, etc.

Dynamic:

- Currently, Peter has impaired decision making due to his psychotic symptoms and given his current dishevelled appearance may be at risk of self-neglect and vulnerability.
- He may be vulnerable to adverse outcomes from police intervention/response if he was to AWA or in the community given his diagnosis and risks for violence.

Foreseeable:

- Accommodation issues, reduction in support from Rebecca.

Queensland Government

Comprehensive Assessment

URN:
Family name:
Given name(s): Peter
Address:
Ph (H):
Ph (M):
Date of birth: Sex: Male

Treatment non-adherence

Static factors (history of)	Y	N	UK
History of absconding	☐	☐	☑
History of breaching MHA orders	☐	☐	☑
Medication non-compliance	☑	☐	☐

Dynamic factors	Y	N	UK
Treatment refusal	☐	☐	☑
Desire/intent to leave hospital	☑	☐	☐
Missed medication	☑	☐	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:

- Peter engaged well during his previous admission.
- Moved from Queensland to Sydney without telling his treating team 6 years ago; appears he had not taken risperidone since this time.
- Following assault of his Uncle Tim, immediately left parents' home in Sydney and moved back to live with Rebecca in Queensland.

Dynamic:

- Peter is currently stating that he does not need treatment and wants to go home.

Foreseeable:

- A high risk scenario for him becoming absent without approval (AWA) will be if he thinks Rebecca is in danger and needs his protection.
- Given Peter's history of disengagement from services and his living situation in an unplanned way, it is foreseeable, that he may suddenly leave again.

Parental status and/or other carer responsibilities

	Y	N
Does the person have responsibility for children aged 17 years or less?	☐	☑
Does the person have any contact with children through access visits or shared residence?	☐	☑
Does the person have other carer responsibilities?	☐	☑
Is there a reasonable suspicion, or risk of harm/neglect?	☐ *	☑

***If yes, contact Child Protection Liaison Officer to discuss Child Protection notification processes**

Details of children and/or other dependents

Full name	Relationship	Age/date of birth	Immediate care arrangements

Protective factors

Peter is motivated to go back to work and has a job.
History indicates that he responds well to risperidone and inpatient care.
Rebecca is considered a protective factor as she has insight into mental illness and supports Peter to engage in treatment.

Overall assessment of risk and plans to mitigate risk

Queensland Government

Comprehensive Assessment

URN:
Family name:
Given name(s): Peter
Address:
Ph (H):
Ph (M):
Date of birth: Sex: Male

Peter's **protective factors** include support from his sister, engagement with this assessment, previous responsiveness to treatment and that the treating team plan to manage his clinical needs/risks assertively.

Peter's risk status for **suicide** is low compared to the inpatient setting (nil history of suicide attempts, no current thoughts). His risk state for suicide is low compared to other points in his life given he is in the care of the mental health service at present. Vulnerability is evident in terms of his mental state deterioration; nil other vulnerability concerns are apparent.

In relation to **violence** risk, Peter has a high number of dynamic risk factors in addition to several static factors. Currently Peter's risk status is higher than others on the ward and his risk state is similar to that of his previous admission six years ago when he assaulted a police officer while psychotic and intoxicated (given current factors including psychotic symptoms, limited insight, recent escalating assaults, secreting weapons, identified target, a fear that his sister may be harmed).

Peter is also at risk of **disengaging from treatment**. His risk status is higher than others on the acute unit and his risk state is higher than one month ago given his mental state has deteriorated to now include active symptoms incorporating his sister's boyfriend Steve. Other relevant contributing factors include that Peter has previously relocated interstate without telling the treating team and that he currently thinks he does not require treatment. If Peter absconds from hospital in the context of any perceptual/delusional beliefs of imminent harm to Rebecca, his risk status/state will increase.

Risk Factors:	**Plans to mitigate risk:**
Psychotic symptoms:	Start on antipsychotic medication, regular MSEs, continued collection of collateral from Rebecca.
Access to weapons:	Weapons alert on CIMHA, weapons licensing notification to Queensland Police Service (QPS).
Access to victims:	Monitor access to Steve. Check regularly if there are any new targets incorporated into his delusions.
AWA:	Manage on locked ward, complete Police Advice and Intervention Plan (PAIP), Acute Management Plan (AMP), high risk AWA plan and alert.
All violence risks:	Refer for a Violence Risk Assessment and Management (VRAM) tool for more comprehensive risk management plan.

Overview/impression	**Y**	**N**	**UK**
Person's level of risk appears to be highly changeable	☑	☐	☐
There are factors that contribute to uncertainty regarding risk screen	☑	☐	
A more comprehensive risk assessment is required	☑	☐	

Formulation

Peter is a 40-year-old male presenting with an increased violence risk in the context of an established diagnosis of schizophrenia and a relapse inclusive of auditory hallucinations of several male voices of the illuminati, racing thoughts, tangential thought form and preoccupation with delusional beliefs incorporating his sister's boyfriend who he believes is "a bad guy". Peter has poor insight in relation to his symptoms and behaviours and associated poor judgement. He reported not using amphetamines in the past 3 months, using alcohol once and a sedative weekly. He has recently experienced a decline in ADLs, been secreting weapons and assaulted his Uncle Tim one month ago. Background of disengagement with treatment 6 years ago.

Diagnoses and Principal Drug of Concern

Primary diagnosis: **Schizophrenia**. ICD-10 Code: F20.

Secondary diagnosis: Substance use disorder. ICD-10 Code: F19

Collateral sources

• Sister, Rebecca.

Queensland Government

Comprehensive Assessment

URN:

Family name:

Given name(s): Peter

Address:

Ph (H):

Ph (M):

Date of birth: Sex: Male

- Interview with Peter.
- CIMHA records.
- The Viewer
- ieMR

Initial management plan

Collateral is outstanding ☐ Y ☑ N

1. Remain in hospital on a TA in a locked ward.
2. For ongoing serial MSE, risk screens and collateral from Rebecca/nursing staff.
3. Recommence risperidone 1mg BD. Consider depot.
4. For UDS, bloods, physical exam please.
5. High risk of AWA plan/PAIP/AMP to be developed ASAP please.
6. Liaise with Mental Health Intervention Coordinator (MHIC) about any criminal history, access to a gun.
7. Complete weapons licence notification prior, add alert to CIMHA.
8. Family meeting to be organised (parents can phone in).
9. Refer for a VRAM tool given risk screen for violence is elevated/dynamic risks.

Queensland Government

Child and Youth Mental Health Assessment

URN:

Family name:

Given name(s): **Luke**

Address:

Date of birth:

Sex: Male

Treatment Status

Mental Health Act 2016 status:	**None**
Conditions of MHA order:	**N/A**
Other status:	N/A

Reason for referral

NB: Clinical documentation would usually include just the specific dates, for training purposes we have added timeframes to aid orientation.

Luke is a 16 y/o male referred via phone by Virginia, Guidance Officer (GO) on XX/XX/XX, after he had punched a student in the back of the head, kicked him twice in the stomach and displayed little remorse. Luke has a history of verbal and less serious physical aggression at school.

Additionally, Virginia held concerns about possible trauma, anxiety, hyper-vigilance, running away from school, communication and difficulty demonstrating empathic responses.

Luke lives with his mother, Jenny and sister, Mindy (14 y/o with an intellectual impairment).

This assessment was completed using information from the GO, CIMHA file review, phone call with Jenny on XX/XX/XX and interview with Luke on XX/XX/XX.

Psychosocial functioning

☐ Consumer requires a functional assessment ☐ Consumer requires a cognitive assessment

Jenny reported a belief that Luke had difficulties making and keeping friendships, and he tended towards doing things his way with limited capacity to negotiate with others.

Luke has continued to use alcohol with peers intermittently since returning to live with his mother.

History of presenting problems

Luke has two episodes of care to date with public Child and Youth Mental Health Services (CYMHS) in Queensland.

First Episode – age of 9
Luke was first opened to mental health services at the age of 9. He was referred by Jenny, as suggested by school, due to significant disruptive behaviour in the classroom and aggression towards other students and his mother and sister.
At the time of his presentation to CYMHS, Luke was experiencing significant anxiety and sleep disturbance on the background of emotional neglect from family/carers who had used illicit substances.
Assessments at age 9 revealed:

- Problems communicating and interacting with peers,
- Disinterest in conversational input from others,
- Challenging behaviour at school/aggression towards others,
- Seemingly not assessing social situations well,
- Rigid/concrete thinking,
- Poor social skills (i.e. avoiding eye contact/limited facial expressions).

Queensland Government

Child and Youth Mental Health Assessment

URN:
Family name:
Given name(s): Luke
Address:
Date of birth: Sex: Male

A diagnostic assessment was booked to investigate a differential diagnosis of autism spectrum disorder vs outcomes of neglect. This was cancelled by Jenny who reportedly disagreed with the formulation and ended Luke's care with CYMHS.

Luke attended several therapy sessions along with his mother and they also failed to attend several appointments. Past notes indicate it was difficult to engage Luke in sessions. Circle of Security parenting support was provided to his mother (her level of engagement in these sessions is unclear).

Luke was prescribed fluoxetine for anxiety. The effectiveness of this medication was difficult to establish, as Luke's adherence was inconsistent.

Child Safety: At the time of Luke's first episode, notification was made to Child Safety due to suspected neglect of Luke and Mindy, and concerns Jenny's capacity to protect Mindy when Luke is aggressive.
Jenny advised a preschool teacher had made a notification of concern to Child Safety in relation to neglect which resulted in no further action.

End of episode diagnoses of:
Z61.8 Other negative life events in childhood
Z62.4 Emotional neglect of a child
Differential diagnosis: F43.1 Post-traumatic stress disorder.

Current (second) episode – age of 16
Jenny reported that approximately 12 months ago, she sent Luke to live with her brother, Daniel. This was due to her having difficulties managing Luke's increasing aggression and violence towards her and his sister. Luke went to live with his uncle for six months. He has mentioned that during this time, his uncle's friends would frequently be at the house using illicit substances.
Jenny commented that since coming home, Luke had slept poorly, experienced nightmares, and that she would find him wandering about the house during the night. He had a reoccurring dream involving a man coming into his bedroom to assault him. He did not know the man in the dream. Jenny worried Luke experienced something traumatic and had avoided discussing this with her.

Queensland Government

Child and Youth Mental Health Assessment

URN:

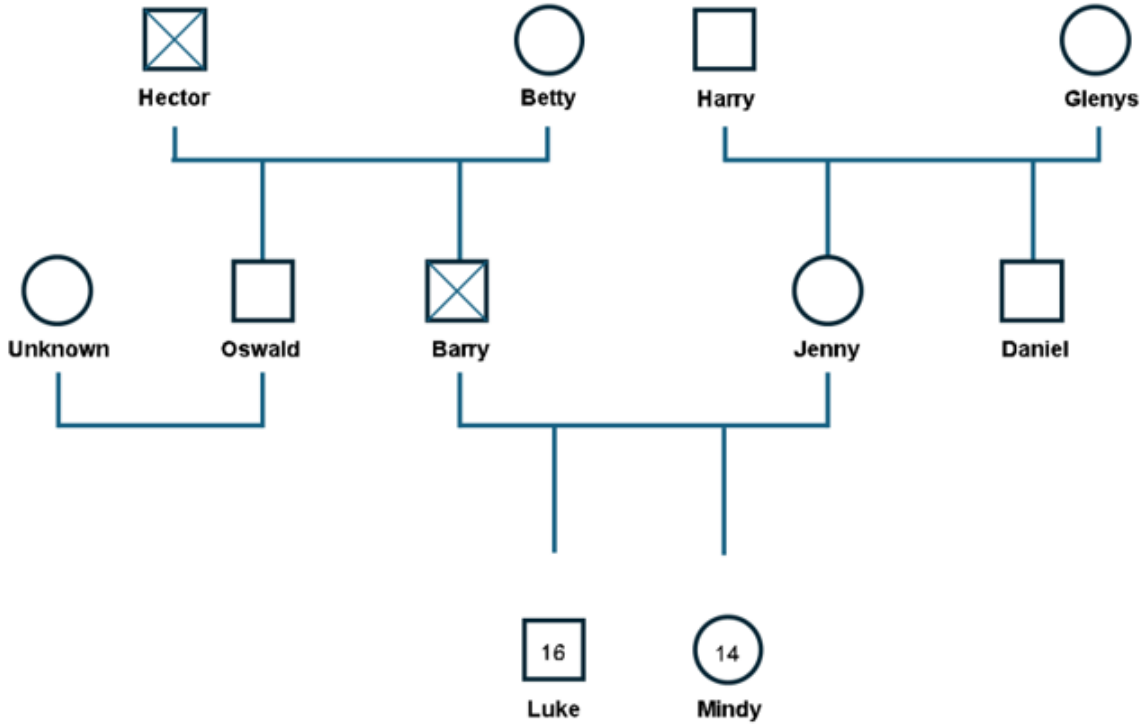
Family name:

Given name(s): Luke

Address:

Date of birth: Sex: Male

Genogram



Family history

Jenny reported a domestic and family violence relationship with her deceased husband (Luke's biological father). She reported Barry used alcohol and was emotionally abusive towards her, also acknowledging substance use had perpetuated some of this violence. Barry passed away after a motor vehicle accident when Luke was aged 3 years.

Jenny said Luke's paternal grandfather, Hector, was emotionally and physically abusive towards Barry. Jenny's parents live in NSW, she has occasional phone contact with them but is in more regular contact with her brother, who lives nearby. Jenny reports a 'mixed' relationship with her brother, Daniel, who has an "outgoing personality and probably partied too much". She said he would support her by doing various tasks if she asked him.

Jenny was sexually abused by an extended family member as a teen and received some counselling for this. She said this had contributed to anxiety related problems and she had been prescribed medication to assist in managing this. Jenny disclosed regular use of alcohol before Barry passed but denied any substance use difficulties at present. Upon

Barry's death, Jenny experienced further depression and financial difficulties, both of which have continued on and off since that time.

Jenny confirmed Luke's sister, Mindy had learning difficulties and an intellectual impairment, and was in a special education unit at the same school as Luke. Luke will often tease his younger sister and, if she does not conform to his requests, he throws objects or hits her. Jenny stated he also demonstrated consistent aggressive behaviour towards herself.

Developmental history

Jenny reported no birth complications with Luke. She remembered he would not settle well as an infant. While she thought he had met all major developmental milestones, she said he did not play well with other children from when he first attended preschool. He did have friends with whom he would play after school; these friendships tended to be brief and then a new friend would appear. Jenny reported assuming that Luke's friends moved on because Luke wanted to have things his own way.

Luke's school described him as capable of doing well with his schoolwork; however, he was frequently distracted in the classroom setting and often interrupted other students.

Current legal issues

Luke has no criminal history. Jenny has not reported Luke to the Queensland Police Service (QPS) for violence towards her or Mindy.

Jenny advised that her husband, Barry, had been convicted of some dishonesty offences.

Health related history including physical, mental health and alcohol and other drugs

☐ Consumer requires metabolic monitoring

Physical health
Nil known physical health problems.
Reported good food intake despite the family's financial difficulties.
Luke said he liked going to the gym at school.

Encounter history
XX/XX/XX – CYMHS COMM - End of episode diagnoses of:
Z61.8 Other negative life events in childhood
Z62.4 Emotional neglect of a child
Differential diagnosis: F43.1 Post-traumatic stress disorder

XX/XX/XX – CYMHS COMM – Awaiting Intake Review

Medications

Medications Ceased

Generic Name (Brand) Strength Form	Status	Reason
fluoxetine (*Brand*) 20mg mane PO	Ceased	Commenced during first episode age 9. Self-ceased after approx.10 weeks
risperidone (*Brand*) 1mg mane PO	Ceased	Commenced during first episode, ? when self-ceased

Queensland Government

Child and Youth Mental Health Assessment

URN:
Family name:
Given name(s): Luke
Address:
Date of birth: Sex: Male

Mental state examination

Appearance and Behaviour - Tall/solid build for age. Casually dressed in shorts, t-shirt and thongs. Nil unusual psycho-motor behaviour. Remained seated. Poor eye contact.
Speech - normal rate and quietly spoken in monotone. Little prosody.
Mood and Affect - Appeared angry upon initial meeting. Reported mood as 'average' and mostly 'fine'. Affect was superficial with little reactivity.
Perception - Not observed to be responding to any external stimuli and denied experiencing any historical or current hallucinations.
Thought form/flow - Thought stream coherent. No thought disorder.
Thought content - No preoccupation or restricted interests. Some concrete thinking and difficulty with perspective taking evident. No delusional thought content.
Denied thoughts of harm to himself or suicidal ideation, intention or planning behaviour. He reported no specific thoughts of harm to others; although expressed attitudes that using aggressive behaviour to address injustices was warranted; and that violence for self-defence was permissible. Future oriented (e.g. attending the gym).
Insight - Luke's insight into his emotions and his behaviours was centred around externalising to situations/others. He did not recognise his aggressive behaviours and violent attitudes as concerning.
Judgement - Luke uses aggression to manage difficult interpersonal situations. Luke stated that he did not like talking to others, and that he did not see a need to do so.
Cognition - Luke was alert and appeared orientated to time, place and person.

Substance use

Q1 ASK CONSUMER: In your life, have you tried:		No	Yes
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	☑	☐
b.	Alcoholic beverages (beer, wine, spirits, etc.)	☐	☑
c.	Cannabis (marijuana, pot, grass, hash, etc.)	☐	☑
d.	Cocaine (coke, crack, etc.)	☑	☐
e.	Amphetamine type stimulants (speed, base, ice, crystal, Shabu, MDMA, ecstacy, etc.)	☑	☐
f.	Inhalants (nitrous, glue, petrol, aerosols, paint thinner, etc.)	☑	☐
g.	Sedatives or sleeping pills (Valium, Serepax, Xanax, Rohypnol, etc.)	☑	☐
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	☑	☐
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	☑	☐
j.	Other (e.g. synthetics, steroids, etc.) specify:	☑	☐

If "No" to all items, continue to next section.
If "Yes" to any items above, ask Question 2 for each substance ever used.
For repeat assessments, compare answers provided to previous screens. Any differences should be queried.

Q2 ASK CONSUMER: In the past three months, how often have you used (first drug, second drug, etc.)		Never	Once or twice	Monthly	Weekly	Daily or almost daily
b.	Alcoholic beverages (beer, wine, spirits, etc.)	☐	☐	☑	☐	☐
c.	Cannabis (marijuana, pot, grass, hash, etc.)	☐	☑	☐	☐	☐

If any substances in Q2 were used in the previous three months, a Child and Youth Substance Use Assessment must be completed

Comments about substance use and addictive behaviours (consider other issues such as gambling in the family, intoxication and/or at risk of withdrawal, motivation for change)

Luke reported experimenting with cannabis and alcohol when living with his uncle.
He had been drinking with peers intermittently since returning to his mother's.

Queensland Government

Child and Youth Mental Health Assessment

URN:

Family name:

Given name(s): Luke

Address:

Date of birth: Sex: Male

Risk screen Y=yes N=no UK=unknown

Suicide

Static factors	Y	N	UK
Previous attempt	☐	☑	☐
Previous self-harm	☑	☐	☐
Exposure to suicide	☐	☑	☐
Stressful life events (mental disorder, physical illness/pain, unemployment, history of trauma, homelessness)	☑	☐	☐

Dynamic factors	Y	N	UK
Suicidal thoughts	☐	☑	☐
Plan (consider detail of plan and access to means)	☐	☑	☐
Loss of hope	☐	☑	☐
Lack of social support	☑	☐	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:
• Denied previous suicide attempts.
• Hit himself when upset when younger, has ceased for several years.
• Stressful life events: parental death, mother's mental health and financial stress, history of domestic and family violence, exposure to parental substance use, sister has an intellectual impairment, school suspension, previous CYMHS involvement, ? autism spectrum disorder and potential trauma when living with uncle (requires further investigation).

Dynamic:
• Denied thoughts of suicide.
• Lacks social support: Currently suspended from school, disruptive and aggressive in school setting, not supported by peers potentially due to his behaviour and/or his social and problem-solving skills.

Future factors:
• ?Trauma reactions, current suspension - school is considering exclusion, stability of living situation/in context of previous aggression at home.

Violence/aggression

Static factors - history of:	Y	N	UK
Violent/aggressive behaviour	☑	☐	☐
Sexually inappropriate behaviour	☐	☑	☐
Domestic/family violence	☑	☐	☐
Criminal charges	☐	☑	☐
Problematic substance use	☑	☐	☐
Personality disorder/s	☐	☑	☐
Other mental disorders	☑	☐	☐
Other problematic behaviour (see comments)	☑	☐	☐

Dynamic factors	Y	N	UK
Anger	☑	☐	☐
Impulsivity	☑	☐	☐
Problematic substance use	☑	☐	☐
Problematic treatment adherence	☐	☑	☐
Violent ideation	☑	☐	☐
Pro-violence attitudes	☑	☐	☐
Symptoms of psychosis	☐	☑	☐
Carries weapon/ **access to firearm***	☐	☑	☐
Exhibits bullying behaviour	☑	☐	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:
• History of verbal and physical violence at home including shouting, throwing objects and occasionally pushing and punching Mindy and Jenny.
• History of violence towards students, especially vulnerable students. Interpreting others behaviour towards him as having hostile or threatening intent on the background of family trauma and him being the victim of bullying.
• Described as having high levels of anxiety and managing this by using aggression to control the environment.

Queensland Government

Child and Youth Mental Health Assessment

URN:
Family name:
Given name(s): Luke
Address:
Date of birth: Sex: Male

• School reported an escalation in his difficult/disruptive behaviours over the previous 3 years and that his behaviour had become more frequent in the past 6 months.
• History of suspensions due to truancy, challenging behaviours, and seeking revenge on peers due to beliefs that others were staring at him.
• Teachers also reported bullying and intimidating behaviours towards female students and more vulnerable students.
• Most serious known act – recent physical assault in which Luke sought retribution two days after an altercation with a student.
    o Punched a student in the back of the head, kicked him twice in the stomach – appeared to be pre-planned (according to PSP collateral)
    o Student required hospital visit to assess injuries
    o Luke is currently on suspension for this incident, pending consideration of exclusion. Little remorse shown.
• Previous experimenting with cannabis.
• Exposure to several adverse childhood experiences – see above.
• Previous response/engagement with CYMHS was limited (in context of parental disagreement with formulation).

Dynamic:
• Ongoing intermittent alcohol use.
• On interview, he expressed views that using aggressive behaviour to address a sense of injustice was warranted and that violence for self-defence was permissible.
• Alterations around limit setting or control with Mother and vulnerable sister.
• Concrete thinking, difficulty with perspective taking and empathy.
• Luke currently minimises the seriousness of past violent behaviour.
• Appears advanced in physical development/may be stronger than many same-aged students.

Foreseeable:
• Possible exclusion from school (currently suspended)
• If returns to school and exposure to student he assaulted - possibility of exclusion if there is future violence .

*Consider the need to notify the Weapons Licensing Branch

Vulnerability

Static factors	Y	N	UK
History of trauma/abuse	☑	☐	☐
History of domestic/family violence	☑	☐	☐
History of financial vulnerability	☑	☐	☐
Cognitive impairment/disability	☐	☑	☐
Lack of family support	☑	☐	☐

Dynamic factors	Y	N	UK
Impaired decision making	☑	☐	☐
Sexually disinhibited	☐	☐	☑
Self neglect	☐	☑	☐
At risk of victimisation (incl sexual)	☑	☐	☐
Impaired interpersonal boundaries	☑	☐	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:
• Domestic and family violence during early childhood, emotional neglect in context of parental substance use, disrupted attachment with mother
• Death of Father (age 3).
• Family experiencing financial hardship.
• Poor insight, judgement and social skills.
• History of running away from school and the family home in context of interpersonal conflicts.

Dynamic/foreseeable:
• Impaired decision making in social contexts due to poor problem-solving, difficulty demonstrating empathic responses and concrete thinking.
• ? Ongoing parental neglect secondary to mother's depression and ongoing psychosocial stressors.

Queensland Government

Child and Youth Mental Health Assessment

URN:
Family name:
Given name(s): Luke
Address:
Date of birth: Sex: Male

Treatment non-adherence

Static factors	Y	N	UK
History of absconding	☑	☐	☐
History of breaching MHA	☐	☑	☐

Dynamic factors	Y	N	UK
Treatment refusal	☐	☑	☐
Desire/intent to leave hospital	☐	☑	☐

Future factors	Y	N	UK
Foreseeable stress/destabilising situations	☑	☐	☐

Comments

Static:
- Run away on several occasions from school and the family home in context of interpersonal conflicts.
- At 9 years, oral medication was not consistently taken (?parental role in this).
- File notes indicate, “Luke had limited motivation to address his behaviour and tended to attribute responsibility for his violence to victims”.

Dynamic/foreseeable:
- Has repeatedly left the school grounds without permission to unknown locations.
- While Luke has limited insight into his mental, social and emotional needs, his behaviours and need for interventions/support - he has engaged with the service for this assessment.

Parental status and/or other carer responsibilities

	Y	N
Does the person have responsibility for children aged 17 years or less?	☐	☑
Does the person have any contact with children through access visits or shared residence?	☑	☐
Does the person have other carer responsibilities?	☐	☑
Is there a reasonable suspicion or risk of harm/neglect?	☑ *	☐

***If yes, contact Child Protection Liaison Officer to discuss Child Protection notification processes**

Details of children and/or other dependents

Full name	Relationship	Age/date of birth	Immediate care arrangements
Mindy	Sister	14 years old	Living with Luke and Jenny (mother) who is primary carer.

Protective factors

- Mother
- School
- Intelligent/high academic results at school.
- Good at sport and likes/attends gym.
- Luke’s current engagement with CYMHS.
- Future oriented.

Overall assessment of risk and plans to mitigate risk

Luke appears to be vulnerable to risk due to misadventure. Known to leave school grounds/run away without permission. Recent serious violence at school on a background of a history of violence at home and school. Appears to misinterpret interpersonal situations in that he senses that he is being rejected by others, treated unfairly or that others are hostile towards him. Risk of violence also seems linked to background neglect/attachment difficulties, possible recent traumatic events on background of DFV, his father’s death, limited problem-solving skills, difficulty demonstrating empathic responses and communication/socialisation difficulties.

Queensland Government

Child and Youth Mental Health Assessment

URN:
Family name:
Given name(s): Luke
Address:
Date of birth: Sex: Male

Risk mitigation plan: Discuss Tier 2 risk assessment at next MDT meeting.

Overview/impression	**Y**	**N**	**UK**
Person's level of risk appears to be highly changeable	☑	☐	☐
There are factors that contribute to uncertainty regarding risk screen	☑	☐	
A more comprehensive risk assessment is required	☑	☐	

Formulation

This is Luke's second episode with mental health services. He has a historic diagnoses of other negative life events in childhood and emotional neglect of a child with a differential diagnosis of post-traumatic stress disorder. Autism spectrum disorder was also queried in the past. Luke and Jenny disengaged with the service before any further diagnostic clarification could be sought.

His current presentation includes signs/symptoms of potential autism spectrum disorder as well as anxiety, hypervigilance, nightmares and frequent waking overnight.

Protective factors include mother (attends to Luke's practical needs and is concerned about Luke and Mindy), attends and enjoys gym, intelligence, school and his engagement with CYMHS and their response.

Diagnoses and Principal Drug of Concern

Primary MH diagnosis: **Post-Traumatic Stress Disorder** ICD-10 Code: F43.1

Collateral Sources

- Interview with Luke.
- Mother (Jenny).
- Clinical record – CIMHA.
- School Guidance Officer.

Initial management plan

Collateral is outstanding ☑ **Y** ☐ **N**

- Refer for Violence Risk Assessment and Management (VRAM) tool.
- In light of possible harm to Mindy, liaise with Child Protection Liaison Officer (CPLO) for further advice regarding child safety.
- Psychiatric review for diagnostic clarification and to determine treatment needs.
- Develop safety plan in conjunction with school and mother.
- Consider attachment-based family therapy or trauma work for all.
- Advocate for counselling support for mother and daughter.
- Psychological interventions re: social skills training, problem solving and trauma counselling.
- Work with school to keep Luke engaged.

Slide 16: Break

Slide 17: Peter interview

To access the full transcript for Peter's interview, either click the link or scan the QR code.

https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Transcripts/20220223_05_PeterInterview_Video_Transcript_v1.2.pdf?forcedownload=1

Peter interview summary

Context: VRAM tool interview is happening 5 days into Peter's inpatient admission.

Risk related information

- Peter said Rebecca's boyfriend Steve has 'got it over her…she just believes Steve rather than me' and that Peter had it wrong about Steve.
- Steve is not a good guy, 'I'm worried he might do something', Peter was more worried a week ago and now he was 'not so worried about it'.
- Peter said Steve's 'a bad dude and he might either do some things to hurt her' or might be a risk to other people or 'kids'.
- Peter knows this as he can 'get a sense about people' and 'can read people really well'. He has an understanding and connection with people that 'are in the know'. This helps him to look out for other people and protect people.
- The information comes from voices that talk about Steve. That he is a 'bad dude' and that he might do the wrong thing. That he is going to cheat on his sister, 'likes kiddies' and is a 'bit of a pedo' and that Peter should worry.
- Peter said he was worried and was watching him and was going to 'look out for my sister and do what I need to do'.
- He said he had a mission to protect whoever is in danger and that no one else was in danger apart from his sister at present.
- Peter had no plans to 'teach' Steve 'a lesson' at present. He was not hearing as much about Steve [from the voices] and thought it was not much of a problem at the moment.
- He never confronted Steve, he just kept an eye on Steve and talked to his sister. She was worried and that's why she brought him to hospital.
- Peter thought Steve was getting his sister to 'think differently' and that he manipulates her. Peter remarked 'that's alright I've got an eye on him; he's not going to do anything bad to her'.
- Peter had knives at his sister's house in a special spot near his bedroom where he can get them and so he knows where they are if things get serious. The knives were described as a kitchen knife and a carving knife.
- Peter said that if he had to, he would 'do whatever needs to be done'.
- He has not previously stabbed anyone.
- He has had fights. He would punch Steve if he had to.
- Peter said he would never hurt his sister, that he was a good guy and that he was going to look after her.
- Peter denied having a gun; although remarked that if he had to, he would shoot Steve.

- He has never had a gun for shooting or hunting. When asked if he had previously had access to a gun he stated ‘yeah, no, nuh’.
- He denied having a police history.

Past violence

- Peter said his uncle Tim had been a problem towards his mother, which he knew by hearing from the group/them telling him stuff that matched up that they were right. They had always been right. He talked to his mum about it but Tim, like Steve, is a real smooth talker and called the police. Peter ‘touched him up a bit’ so he won’t be coming near his mother again. Peter was unsure if Tim had to go to hospital after he assaulted him. The police attended and talked to them and ‘they didn’t really buy into it either’ [unclear what this means].
- Peter left Sydney after he assaulted his uncle and came up to Queensland (QLD).

Mental state/Mental health history

- Peter reported he was ‘fine’ and ready for discharge.
- Peter’s been admitted for 5 days. He thinks he is under the Mental Health Act (MHA). He doesn’t think the treatment he is on does a lot but that it is alright, and that he has to take it so he will. He wants to be able to sleep, and implied medication will assist with this.
- He wants to go home to see his sister/doesn’t think he needs to be in hospital. He does not agree he has a diagnosis of schizophrenia.
- He is always going to keep an eye on Steve, at present he has a sense that things aren’t as bad as what they were, so he doesn’t have to worry so much.
- He has reported him to the police (as he did with Tim).
- Peter said it’s his ‘special role’ to protect his sister.
- He had been hearing voices and experiencing a sense he knew a lot about people for more than six years.
- He does not find the voices distressing. It gives him a job to do – to worry about people near him and the ‘kiddies’ and to make sure things don’t happen – it is his job.
- Peter agreed he had his first contact with the Mental Health Services (MHS) in QLD about 6 or 7 years ago. His experiences now were similar to what happened back then. The voices are ‘really there’ sometimes and sometimes they are not a problem.
- He said it is good/he feels good when he hears the voices as he knows what is going on/keeps him in the loop. He was unsure what reduced or increased them.
- He reported a paternal uncle had ‘nervous breakdowns’.

AOD

- Peter reported he drinks alcohol and takes Valium or Xanax to dampen down ‘the group’. He denied using illicit drugs.

Consent

- Peter consented to the Tier 2 clinician contacting his sister, Rebecca and the Mental Health Intervention Coordinator to request his police history.

Slide 18: Luke interview

To access the full transcript for Luke's interview, either click the link or scan the QR code.

https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Transcripts/20220223_05_LukeInterview_Video_Transcript_v1.2.pdf?forcedownload=1

Luke interview summary

School

- Luke is in Year 12.
- He reported the current school suspension is 'stupid' and 'really dumb'. Luke thought that he did not do anything wrong, and the other student should have been suspended.
- The victim (Tyson) is in Year 12 too. Luke initially stated he 'kind of punched him' and expanded to note that he ran up behind Tyson, punched him in the head and Tyson then hit the ground at which point Luke 'kicked him a couple of times' and then left.
- Luke said he did this because the victim had looked at him 'funny' a couple of days beforehand and had been picking on him 'all the time'. Luke said he had been thinking about it for a few days and when he saw the victim in the yard he got 'so angry'.
- Luke made statements such as 'I didn't hit him that hard' and 'he deserved it'.
- He reported Tyson's friends also pick on him and look at him funny.
- Luke's view is that he can tell by the way Tyson looks at him that he is judging him, 'having a joke' and Tyson/his friends joke about him. Luke said there had been a lot going on this year and it's just all built up, that he did not feel bad about what happened, and that the victim deserved it as he'd just been pushing and pushing.
- Luke thought other people who had been teasing him and 'looking at me funny' also deserved being hit.
- He has previously thought about hitting people at school because of what they were doing to him.
- While Luke acknowledged there are things in the environment that people can use as weapons (e.g. beating someone to death with a book) he denied stockpiling knives or access to a gun.
- Luke thought school was going well and he was continuing to get good grades.

Home

- Mindy (sister) says 'stupid things all the time' which gets really irritating after a while. Luke said this builds up and that he might yell at her and get angry, over 'stupid sibling shit…siblings fight, yeah'. Every now and then his mum has to tell them to stop.
- Luke reported his mother also does 'stupid stuff' and they have a 'yelling match' and 'start screaming at each other'. He has also pushed his mother a couple of times and 'maybe once' he hit her when he was really upset/irritated by something she said. He felt bad after as he doesn't want to hit his mum.
- His behaviour got too much for his mother, and she kicked him out, he went to live with this uncle. He still feels a bit angry about this towards his mother as she made this decision/he didn't have any say over it.
- Luke mentioned he feels like others push him around and that Mindy is not treated in the same way because of her disability.

- Luke said he missed school a couple of days while at his uncle's place and that there were parties there. He declined the offer to talk about what else happened while he was there.
- Luke reported drinking alcohol with friends at the park at night, mostly on weekends, and approximately one third of a bottle of vodka.
- He denied drug use.

Mental state

- Regarding people talking about him or looking at him strange, Luke reported he is constantly on the lookout now and expecting 'people are going to be shit'.
- This makes him feel irritable and 'pissed off' and more reactive as he is constantly worried about what people are going to say. This also makes him unhappy.
- In the future he may go to Uni and is not sure. He has no specific plans at present.
- Luke said he hangs out with friends to play video games with violent themes ('not that violent') and go to the gym.

Slide 19: Collateral

Peter collateral

To access the full transcript for Peter's collateral phone call, either click the link or scan the QR code.

https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Transcripts/2_Peter%20Collateral_v_1.0.pdf?forcedownload=1

Peter collateral summary: Phone call with Rebecca (Peter's sister)

Fight with uncle Tim and details from when living in Sydney

- Peter moved in with Rebecca about a month ago. He was with his Mum/Dad in Sydney where he got into a fight with Uncle Tim and had to leave. Rebecca described him as 'pretty unwell'. Peter's parents were worried about him as he was saying odd things about Tim and calling the police.
- Peter thought his uncle was hurting his mother as the ''Illuminati'' told him this. He was 'a bit weird' around Tim at first and then started to ask his mother if Uncle Tim had hurt her.
- Rebecca reported that her mother would not put up with any violence and that Uncle Tim was not hurting her mother.
- Peter sent his sister photos via text of his mother saying 'see the bruise'; however, there were no bruises, and the sister was worried by this behaviour.
- Peter called the police, who attended to speak to Peter's mother and uncle, before warning Peter for misusing Triple Zero and 'making up stories'.
- Immediately after this, Uncle Tim visited, and Peter ran into the front yard and started punching him. Tim was knocked to the ground and Peter 'kept swinging punches'. Peter stopped and ran off when his parents and the neighbours yelled at him. The uncle went to hospital for scans and had bruising and headaches.
- Peter said to Rebecca that he hurt Uncle Tim as he was 'a pig' and had hurt his mother. Peter was also saying strange things around this time, similar to what he has said about Rebeccas' boyfriend, Steve. For example: 'I know who you really are' and 'I know what you've done'.
- Peter packed his things and went to the bus while his parents were getting help for the uncle. He let his sister know he was coming straight there via a phone call. During this call he was making statements about his parents siding with the uncle and that he could not stay with them anymore. Rebecca's mum later told her about the assault.
- In the lead up to the assault, Peter was living with his parents, working, mostly stayed at home and then got 'really paranoid' and started talking about the 'Illuminati' again.

Behaviours towards Steve

- Once Peter came to his sister Rebecca's place, he stopped talking about the 'Illuminati', got a job with his old boss at a café, went out with friends a few times and 'settled in okay'.
- Steve stays over a lot at Rebecca's.
- Steve is understanding and supportive of Peter, has tried to create a relationship with Peter and has never harmed Rebecca according to her self report.
- Peter was initially a bit distant from Steve. Peter then became 'quiet' and would only speak to his sister if she made conversation.

- He was working as a kitchen hand in the mornings and would then self-isolate in his room or stare at the TV in the evenings.
- He was not using alcohol or drugs. It was unclear how often he was eating or if he was showering. He was likely not sleeping at night as his light was usually on. He was not doing his laundry.
- He would mention the 'Illuminati' and the missions they had planned for him. Sometimes he would close his eyes and mutter under his breath/talk to himself.
- Peter then became focused on Steve. He started glaring at Steve/following him around the room with his eyes and asking his sister if Steve had hurt her. Rebecca confirmed that Steve has not hurt her.
- Peter also asked if Steve was a paedophile.
- About a week before hospital, he started to confront Steve and say things like 'I'll find out what you did, just wait until I have proof, and if you've actually done it, you'll pay. I'll shoot you in your sleep'.
- Rebecca tried to talk to Peter, and he responded by saying things like 'your boyfriend's a pervert, you can't have a baby with him' and would mumble to himself. He was always pacing around the house or his room and muttering.
- Peter had also talked about the 'Illuminati' and 'this group' telling him that Steve was a bad guy.
- While Peter was at work, Rebecca found two big kitchen knives in his room and later took him to the Emergency Department (ED).
- Rebecca said that Peter has never shot a gun.
- He does not have access to other weapons.

Personal supports

- Peter's parents have forgiven him for the situation with his uncle; however, they do not want him to live with them anymore. They continue to have phone contact.
- His sister was 'really freaked out this time' and can't continue to have him live with her. She will stay in his life/visit him.
- His boss sent a card to hospital and invited Peter to give him a call when he gets out of hospital.

Strengths

- Good work ethic and can always find work.
- When well Peter was described as good to his family and a nice person.
- He played video games and read when younger.
- The treating team are planning a family meeting and will invite parents to attend by phone.
- Sister now has contact details for treating team.

Luke collateral

To access the full transcript for Luke's collateral phone call, either click the link or scan the QR code.

https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Transcripts/4_Luke%20Collateral_v_1.0.pdf?forcedownload=1

Luke collateral summary: Phone call with Jenny (Luke's mother):

School

- Jenny said Luke can 'fly off the handle a bit' and he told her what happened was because Tyson had been 'eyeballing' Luke a few days prior to the assault and that they don't get on. Luke saw Tyson near the oval during lunch and suspected Tyson did not realise he was there and figured 'he could get a few hits in'. Luke hit Tyson in the back of the head and Tyson went straight down and then Luke kicked him 'pretty hard in the stomach' and ran off before the teachers could see him.
- The victim was curled up groaning when the staff found him, and he was taken to hospital.
- Jenny said 'there's no broken bones. And all's well that ends well' and that Luke said Tyson was giving him grief 'so he might have deserved it'.
- Jenny reported that Luke had been in trouble for fights and bullying before, including being suspended once or twice. She thought things 'really picked up about three years ago' as she started getting more calls from the school, although she was unsure what changed, offering it may be puberty/hormones.
- Jenny stated she was unsure what sets him off at school, although noted Luke assumes people are out to get him and that this must make it easy for other kids to 'piss him off' even when they don't mean too.

Home

- Jenny described Luke's aggression at home as being characterised by punching walls, pushing, yelling and slamming doors. And that if he is frustrated with school or his mother, he often takes it out on Mindy as she's an easy target. He has 'put his hands' on Mindy when he's frustrated.
- Jenny and Luke get into shouting matches a lot. He's pushed her around a bit, although not as much as he does with Mindy. This violence really bothers her, and she is at a loss to know how to stop it, particularly as he is growing bigger and stronger.
- Jenny remarked that Luke reminds her a lot of his dad when he's angry.
- Jenny reported Luke 'flies off the handle' when he doesn't get his own way e.g. if he wants to go out with his friends and she says no, that will set him off. Or if Jenny asks him to do things he doesn't want to do, she said that 'it's like World War III'.
- Jenny was unsure about specific high-risk situations as she said it's hard to know when he will 'go off' and that people around him will 'cop it'. She thought that he didn't target anyone in particular apart from her daughter and that this was because she was always in close proximity.

Background

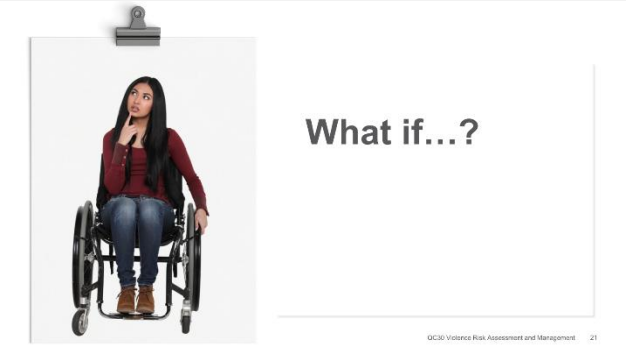
- Jenny reported that Luke was always easily frustrated, even as a baby he was hard to settle and always tended to act out when things were not going his way.
- Jenny mentioned that she sent Luke to stay with his uncle as she could not handle his anger. After a few months Luke started saying he hated it, was begging to come home.

As he doesn't usually get like that, she told him he could return if he kept his behaviour under control.

- Since returning he was unusually secretive about his time there and shuts down when she brings it up. He has been more anxious, will jump at the smallest thing, was spending more time in his room and his mood seems more irritable or uncomfortable. He has bad nightmares and trouble sleeping as he often thinks someone is coming into his room when he is trying to sleep and that this is the theme of the nightmares. He is now leaving the light on at night which is out of character.
- Jenny remains unsure what happened to Luke while he was at his uncle's. She confirmed that her brother uses drugs and had parties while Luke was there and that although she is unsure how she will cope on her own with Luke's behaviour that she would not send him back to her brother's.

Slide 20: Documentation check

Slide 21: What if…?



Notes:

Slide 22: Break

Slide 23: Violence risk summary (formulation)

What to include in a violence risk formulation?

- ❑ 5 Ps
- ❑ Violence specific subsections:
  - High risk scenarios
  - early warning signs
  - foreseeable changes
  - victim group
  - probable nature of future violence
  - imminence of future violence.
- ❑ Risk state and risk status

The risk summary is clearly linked to the data.

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Below is an example of one way you might document the violence specific subsections for *violence* risk.

This example uses a **different scenario** to the one in the workshop - a person named **'Jay'**.

High risk scenarios: Jay has previously tended to engage in more serious violence when experiencing high risk psychotic symptoms (including commands to stab others to protect their family). This typically occurs after a rapid deterioration in mental state secondary to stressful life events such as their mother dying (just prior to the allegations against the police officer) and the cat dying (just prior to the violence aged 23).

Early warning signs (for violence): Early warning signs for violence (based on previous episodes of violence) include withdrawal from services, not taking oral medication, talking about spirits and demons and increased preoccupation about being spied on by police.

Foreseeable changes: Jay has a court hearing in two months on XX/XX/XXXX and this may lead to them being released on bail (according to their lawyer). This will need consideration/planning ahead of court as they are currently a Classified Patient.

Victim group: The person at greatest risk is the previous alleged victim (the police officer Jay stabbed). This risk is somewhat ameliorated as they are no longer fixated on the police officer. Nobody else has been incorporated into Jay's beliefs at present.

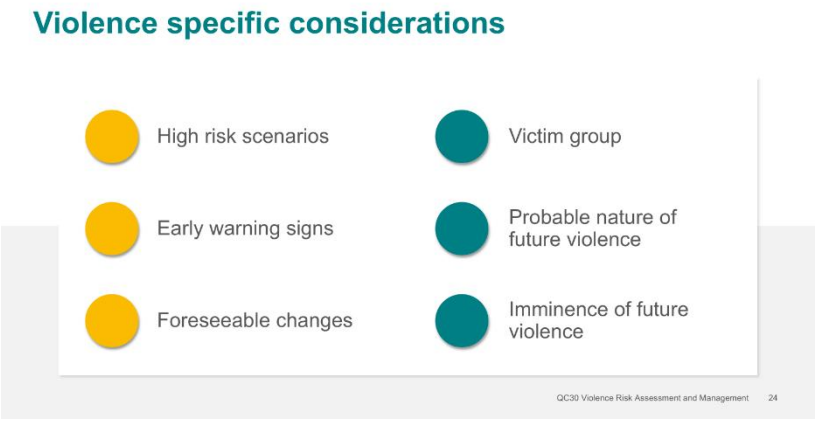
Probable nature of future violence: Jay has exhibited a pattern of escalation in their violence, commencing in their teens with school yard fights, progressing to unlawful wounding when 23 and more recently (aged 29) been charged with attempted murder of a police officer with a kitchen knife. Jay's next episode of violence may involve a weapon and be fatal.

Imminence of future violence: As Jay is currently an inpatient and no longer experiencing command hallucinations for violence (responsive to recommencement on clozapine), imminent risk is unlikely at present. Jay is regularly monitored in this environment, including for symptoms, adherence/responsiveness to oral medication, and access to weapons as well as victims. As some of the precipitating and perpetuating factors are still present, Jay may be at imminent risk of further violence if they were to leave hospital or be discharged to the community in the near term.

Risk status: Jay is a higher risk of violence compared to others in the inpatient environment as they have exhibited a pattern of escalation in violence, culminating in the current charges of attempted murder. This was in the context of high-risk psychotic symptoms (including commands to stab others to protect their family) which are now resolving.

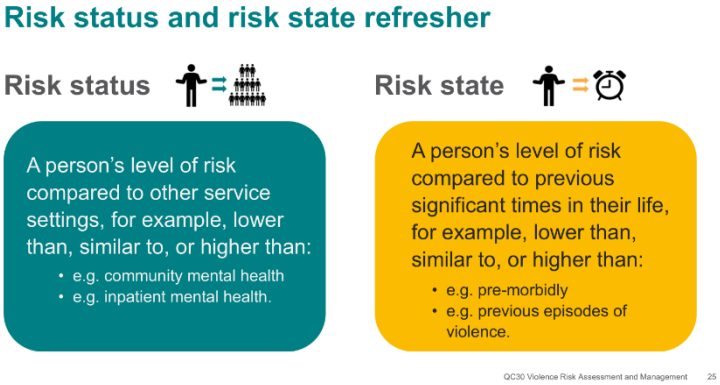
Risk state: Jay's risk of violence is lower than when they were admitted seven weeks ago as Jay is no longer fixated on the police officer or anyone else at present, is regularly monitored in hospital, is not able to access previous victims, is not currently demonstrating identified warning signs for violence, has engaged in treatment and their symptoms have responded well to this treatment. As some of the precipitating and perpetuating factors are still present, Jay's risk state may change if they were to leave hospital or be discharged to the community in the near term.

Slide 24: Violence specific considerations



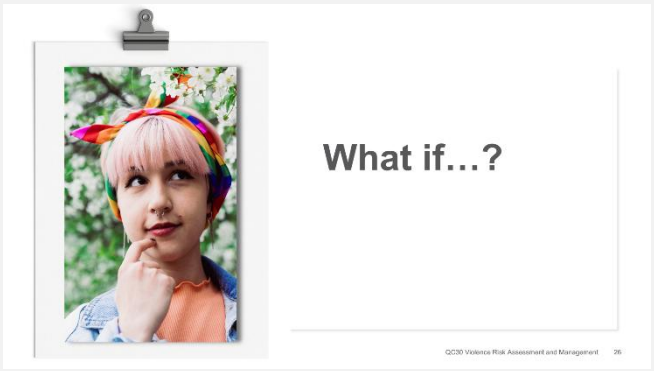
Notes:

Slide 25: Risk status and risk state refresher



Notes

Slide 26: What if…?



Notes:

Slide 27: Break

Slide 28: Risk management planning

Focus on prevention

- Target the violence risk increasing factors and strengthen protective factors
- Define the clinical goal for these factors
- Develop prevention strategies, interventions and appropriate involvement of other services.

QC30 Violence Risk Assessment and Management 28

Notes:

Slide 29: Slido question

When it is time, scan the QR code for Slido.	

Slide 30: Prevention oriented risk management plan

Prevention orientated risk management plan

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.

This section of the VRAM tool tipsheet is recommended to be used in conjunction with the Adult Strategies for Managing Violence or the Child and Youth Strategies for Managing Violence.

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
List **identified risk factors** that are relevant to the person and require intervention to reduce the risk. Every identified risk factor needs to be listed/addressed. If there is unknown/missing information, include this as a risk factor and identify goals and strategies to address this risk.	**What** are we going to do? For each risk factor, document a goal that intervention aims to achieve.	**How** are we going to do it? Consider **recovery orientated** principles and approaches. Make them **SMART** for example: • list one or more **specific** strategies • list in a stepwise manner • document who is proposed to carry tasks out and estimated dates for review or completion dates.
Example: Access to weapons (E.g. The person reported they currently have a crossbow, chainsaw, 3D printed gun and registered firearm at home).	Reduce access to means	By (date), PSP to: • For any future imminent or urgent safety concerns about someone's behaviour or access to a weapon, call Triple Zero (000)

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Notes:

Slide 31: Risk increasing factors

Slide 32: Practice support resources

Slide 33: Protective factors

Slide 34: What if…?

Notes:

Slide 35: Slido QR code

When it is time, scan the QR code for Slido.

Slide 36: Is a Tier 3 referral needed?

Is a Tier 3 referral needed?

What if…?

Notes:

Mental Health Alcohol and Other Drug Services

Assessing and Responding to Violence Framework

First Nations and Transcultural support

At all stages of engagement, consider whether you need input from an Indigenous Mental Health Worker or Queensland Transcultural Mental Health Centre

Domestic and family violence?

Talk to your local DFV specialist about a referral for specialist assessment

Imminent risk to someone's safety?

Call 000

Tier 1

Screening all consumers for static and dynamic violence risk factors

CIMHA Risk Screen completed

- **Upon entry to the service**
- **When there is a change in violence risk**
- **When there is a transfer of care**
- **Every Care Review**

Assess by talking with the consumer, their family, carers and support networks, and reviewing electronic medical records

→

Discuss at Care Review meeting (ad hoc if more urgent) and consider:

- Elevated violence risk factors in Risk Screen
- Is there a risk management plan?
- Does there need to be further investigation of violence risk?

→

Decision to move to Tier 2

- Is the risk understood?
- Is the current management plan mitigating risk?

If unsure, talk to your Forensic Liaison Officer or forensic mental health service

→ **Yes** **Tier 2 not indicated**

Record Decision and Care Plan in CIMHA

- Outline risk management plan in Risk Screen and Care Review
- Incorporate into Care Plan
- ***Continue*** **to review violence risk in Care Review meetings**

→ **No** **Complete Tier 2 VRAM tool**

Complete Tier 2 Violence Risk Assessment and Management (VRAM) tool

- Record team decision to escalate to Tier 2 in CIMHA (Care Review and Risk Screen)

Tier 2

Thorough assessment of violence risk and creation of a risk management plan by the treating team

When to do a Tier 2 VRAM

- **Elevated risk and current management plan is not mitigating the risk**
- **Assessment and Risk Management Committee (ARMC) recommendation**
- **VRAM can be used for any violent or problem behaviour (e.g., stalking, threats)**
- **Discuss with your Forensic Liaison Officer or forensic mental health service**

Complete VRAM

Assess by talking with the consumer, their family, carers and support networks, and reviewing electronic medical records

→

Discuss at Care Review meeting (ad hoc if more urgent) and record outcomes on CIMHA:

- Discuss VRAM recommendations
- Incorporate risk summary and recommendations into Care Review and Care Plan
- Incorporate relevant information from VRAM into Longitudinal Summary
- **Review risk at each Care Review meeting** to check if risks are understood and management plan remains sufficient
- Consider review at an ARMC

→

Decision to move to Tier 3

- Is there recent **serious** violence or an escalation in violence or problem behaviour?
- Have all risk management strategies from the VRAM been actioned but are not mitigating risk?

If unsure, talk to your Forensic Liaison Officer or forensic mental health service

→ **Yes** **Tier 3 indicated**

- Discuss with your Forensic Liaison Officer or Forensic Child and Youth Mental Health Service
- Refer to specialist forensic mental health service using local processes
- Referrals can be made by any clinical staff member

→ **No** **Tier 3 not indicated**

- Outline risk management plan in Risk Screen and Care Review
- Incorporate into Care Plan
- Update VRAM if:
  - Different behaviour to what last VRAM addressed
  - Drivers for violence have changed

Tier 3

Referral to specialist forensic mental health service (Community Forensic Outreach Service/Forensic Child and Youth Mental Health Service)

Tier 3 assessment completed

→

Actions after Tier 3 management recommendations received:

- Talk about recommendations with your team
- Record discussion in CIMHA Care Review
- Discuss anything you are unsure about with the forensic mental health service
- Incorporate recommendations into Care Plan and record in CIMHA
- Incorporate relevant information into Longitudinal Summary
- Consider review at an ARMC
- **Review recommendations at every Care Review or whenever the consumer's violence risk changes and continue to record these discussions in CIMHA**
- Hand over recommendations when there is a transfer of care

Recommendations remain relevant for as long as the behaviour is at risk of occurring

When is an updated Tier 2 VRAM or re-referral to Tier 3 indicated?

When previous VRAM or specialist forensic mental health service recommendations are no longer mitigating risk

VRAM vs Tier 3?

- Talk with your team about the best option
- Talk with your Forensic Liaison Officer or forensic mental health service
- Consider review at an ARMC

For further information and resources in relation to the ***Assessing and Responding to Violence Framework***, please refer to the *Mental Health Alcohol and Other Drugs Branch Comprehensive Care: Partnerships in Care and Communication* webpage on QHEPS

Queensland Government

ARV Framework: Escalation across the tiers

Decision to move to Tier 2: What may indicate a need to escalate to Tier 2 (VRAM tool)

- Recent violent behaviour or violent ideation with potential to cause harm to self or others.
- Behaviour that places the consumer at risk of criminal charges and/or poses a threat to others.
- A documented history of serious violent behaviour in the presence of current dynamic risk factors.
- Challenges in managing the consumer's violence risk, or behaviours contributing to that risk.
- Uncertainty regarding the pathways or triggers of previous violence.
- Lack of clarity around current or future triggers and warning signs (future factors) for potential violence.
- Escalating agitation, aggression, or threats.
- Escalation of violence towards others.
- Identified triggers or stressors that increase the likelihood of unsafe behaviour.
- Significant changes in psychosocial circumstances, supports, or environment that increase vulnerability or disinhibition.
- Clinical deterioration or reduced capacity for self regulation.
- Increasing fixation on or use of weapons, including expressed intent or access.
- Threats, relationship breakdown (particularly in the context of intimate partner violence), or 'end-of-relationship' dynamics.
- Other concerning behaviours such as sexual violence, stalking, or fire-setting.
- High risk psychotic symptoms, including passivity phenomena, command hallucinations, or delusions of misidentification.
- Expressions of 'last resort' thinking, hopelessness, or perceived lack of alternatives.
- New or recent forensic orders and Treatment Support Orders (TSO).

Decision to move to Tier 3: What may indicate a need to escalate to Tier 3 services (CFOS or Forensic CYMHS)

- there is evidence of serious violence, escalation in violent or problematic behaviours, and
- all risk management strategies from the VRAM tool have been actioned but are not effectively mitigating the identified risks
- under the *Chief Psychiatrist Policy*: Forensic order (Prescribed offence) require a review by CFOS within 60 days of the Order being made. Prescribed offences include: murder, attempted murder, manslaughter, grievous bodily harm, and rape and attempted rape.

(Source: ARV framework, 2026)

The link to the full ARV Framework was not available at time of publishing.

<<TO BE CONFIRMED>>

ARV Framework: Example of escalation across the tiers

Decision to move to Tier 2: Example

Ollie moved from New South Wales to Queensland three weeks before his first review by the Mental Health Service. This initial review happened after the police picked him up on the main street following reports that he was harassing an elderly female who was unknown to him. At this time, he had told the police he drank a carton of beer and that the devil told him that 'elderly females are the fruit of the earth'.

Ollie mentioned at the initial review that he had been in prison in Victoria for rape. He also said that after he assaulted his brother, he was 'put in hospital' last year, where he assaulted nursing staff.

A risk screen was carried out. However, Ollie was not able to provide specific details about his past history of rape and the assaults on his brother and the nursing staff.

As the treating team was unsure of the contributing factors to his past violence and potential for future violence, it was decided to escalate to Tier 2 for a Violence Risk Assessment and Management (VRAM) tool to be completed.

Rationale to move to Tier 2

This would enable the service to gather collateral from interstate health services and from local police, work up a formulation of his violence risk, and from there develop a robust prevention oriented risk management plan.

The VRAM was completed within four weeks and implemented by the PSP/treating team.

Decision to move to Tier 3: Example

Ollie had a VRAM tool completed and the team put the prevention orientated risk management plan recommendations into place. Despite this Ollie continued to come to the attention of the police after his discharge for a range of non-violent offences.

Several months after the VRAM tool was implemented, Ollie was charged with possessing child exploitation material, stalking and assault on a police officer. He was bailed to reappear in 4 months.

Ollie was vague when attempts were made to update the VRAM tool and unable to provide any information about what happened to result in the charges. On mental state examination (MSE) he reported believing that 'children are in love with him as he is the saviour and will free their souls'. He also mentioned that his sexual functioning/drive had increased, and he was masturbating several times per day.

Rationale to move to Tier 3

The VRAM tool was in place while further police charges were incurred, there is a diverse range of harmful behaviours/allegations, changes to the victim group/targets of harm, escalation and also some concerning symptoms requiring a specialist Tier 3 assessment and advice regarding future management.

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VRAM tool example responses

Peter's VRAM tool information gathering section

Queensland Government

Mental Health Services

Violence Risk Assessment and Management

Facility: INPATIENT

Date: Time:

(Affix identification label here)

URN:

Family name:

Given name(s): PETER

Address:

Date of birth: XX/XX/XX 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:

☐ An interpreter was used

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

Referred by ward staff to determine risk increasing factors for ongoing violence risk, and to establish a comprehensive management plan. Distinguish violence risk from mental health symptomatology. Inform long-term treatment.

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.

Peter is a 40 y/o male who grew up in Sydney. In his early 20s he moved to Brisbane to live with sister (Rebecca). When aged 34, he moved back to Sydney to live with parents about 6 months post-discharge from hospital. Approximately 1 month ago, age 40, he moved back to Brisbane to live with Rebecca following assault of uncle (Tim).

Peter is diagnosed with Schizophrenia with likely onset around age 19; he had identified that this is the age which the 'Illuminati' singled him out for special missions. His symptoms include auditory hallucinations of the 'Illuminati', grandiose and persecutory delusions and mental state deterioration is accompanied by a decline in activities of daily living (ADLs), including day to day functioning. Over the years he has typically maintained employment and when well is described as likeable.

He has a history of substance use. He started drinking age 17, commenced cannabis and amphetamines soon after, history of using sedatives (Xanax, Valium) when becoming overwhelmed with auditory hallucinations.

He is currently under a Treatment Authority (TA).

This is his second known admission. Brought in by sister Rebecca (who he was living with) after she found two large kitchen knives hidden in Peter's room in context of menacing behaviour towards her boyfriend (Steve), including threats to shoot him in his sleep (muttered by Peter to Steve). Peter had incorporated Steve into persecutory beliefs.

Has current and historical delusions that he receives messages from the 'Illuminati' (auditory hallucinations) informing him of people who are 'bad'. Also believes that it is his responsibility to stop 'bad people'. He was not engaged in treatment at the time of this admission.

His first admission was 6 years ago and fell out of care not long after.

Two known incidents of violence (1 month ago, 6 years ago) in the context of psychotic symptoms, as well as reports of pub fights in his 20s in the context of substance use.

Nil known criminal charges.

Peter was not at risk of suicide or vulnerability.

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)

Approx. 1 month ago

Peter beat his uncle (Tim) in the front yard of his parent's house in Sydney (where he was living at the time). Tim was punched several times in the head; no weapons were used. Resulted in bruising and headaches, scans were required to confirm no lasting damage. Immediately prior to this incident, Peter had called the police to report Tim for harming his mother. The police arrived and found that this claim was unsubstantiated. When Peter realised the police would not take action against Tim, he reported he beat Tim with the aim of preventing harm to his mother.

For some time prior to this incident, Peter had been experiencing auditory hallucinations of the 'Illuminati' telling him that Tim was assaulting his mother, visual hallucinations of bruises on his mother, and had the delusional belief that it was his responsibility to punish Tim for this to stop him assaulting Peter's mother. Collateral reports from Rebecca suggest that it is unlikely that Tim was assaulting his mother. Police were not called about Peter's assault of Tim, and Tim did not press charges. Peter then left for Brisbane to live with Rebecca immediately following this incident.

In 20XX (age 34) – 6 years ago

Peter was admitted after he hit a police officer, reportedly as a result of hearing voices from the 'Illuminati' telling him that the officer was a paedophile. This was reportedly impulsive (not premeditated). Peter also believed that he had 'secret powers' and an unusually high intellect at this time. Peter had been drinking immediately prior to this incident. Urine Drug Screen (UDS) was positive for cannabinoids and amphetamine. Admitted to hospital at this time due to psychiatric concerns. Engaged briefly in community treatment but soon failed to attend appointments – moved to Sydney to live with parents without informing treating team approx. 6 months post-discharge. Queensland Police Service (QPS) declined to press charges for assault on police officer, given Peter's mental health problems.

Earlier violence

Reported occasional pub fights in his 20s while intoxicated with people he found annoying to get them to 'shut up' or 'teach them a lesson'. He has reported that no one was significantly hurt, and he was not charged. The fights were started by Peter when 'people are talking rubbish'. He said he usually went for 'one good hit' then stopped. He intended for the punch to teach victims a lesson, and to 'get them to shut up'. After this Peter did not feel the need to continue the fight. Peter confirmed he was not being treated for 'the voices' he was also experiencing around this time.

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

- History of trauma (Peter was sexually assaulted by a male teacher in Grade 10).
- History of violence.
- Previous diagnosis of schizophrenia.
- Substance use history.
- Prior admission to hospital 6 years ago. Lost to follow-up.
- Factors previously identified on risk screen: anger, impulsivity, treatment non-adherence, violence ideation, symptoms of psychosis, secreting weapons (knives).

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.

- Falling out of treatment.
- Auditory hallucinations and persecutory/grandiose delusions of victims assaulting others or being paedophiles, and Peter being on a mission from the 'Illuminati' to stop this.
- Lack of insight into mental illness and violence risk.
- Alcohol use (linked with violence in 20s).
- Where he was living/access to victims.
- Secreting weapons (knives).
- Anger.
- Impulsivity.

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

- Ongoing active symptoms of Schizophrenia (Similar symptom profile preceded previous violent incidents):
  - Ongoing delusions about Steve being a 'bad guy' and that he will hurt Rebecca and requesting to call police.
  - Currently responding to non-apparent stimuli, voices of 'the 'Illuminati'' telling Peter that Steve is a 'bad guy', that he'll 'hurt Rebecca', that he'll 'cheat on Rebecca', and that 'he's a paedophile'.
  - Psychotic rationalisations/justifications leading to a willingness to use violence to protect Rebecca from Steve.
- 'Menacing' behaviour towards Steve prior to admission which was escalating in intensity: Glaring, following around room with eyes, asking Rebecca if Steve hurts her, asking Rebecca if Steve is a paedophile, 'I'll find out what you did, just wait until I have proof' and 'If you've actually done it, you'll pay. I'll shoot you in your sleep'.
- Has been hiding knives in his bedroom in anticipation of altercation with Steve (according to Rebecca).
  - Some evasiveness and incongruence in self-report about location of knives.
- Denied access to guns, but reports willingness to shoot Steve.
- Rebecca reports that Peter has threatened to shoot Steve in his sleep.
- Self-isolating before admission to hospital – spending most of time in room, no close friends.
- Decline in Activities of Daily Living (ADLs) prior to admission (especially eating, sleeping, washing clothes, showering).
- Limited insight into his diagnosis, nature of mental health problems, current risk, need for treatment and consequences of declining treatment.

Foreseeable changes

- Sister recently informed staff that Peter can no longer reside with her. Parents also can no longer care for Peter.
- May abscond from hospital to pursue Steve - especially once informed he can no longer live with Rebecca.
- Peter may leave the state without informing health services.
- Given previous pattern of moving following violent incidents, some risk that Peter will leave Queensland without informing health services.
- Given Peter's delusional belief that Steve is a paedophile, the risk to Steve is likely to increase if Rebecca falls pregnant.

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.

Current inpatient

- Peter reported he was 'fine' and ready for discharge. He wants to go home to see his sister/doesn't think he needs to be in hospital. He does not agree with views that he has a diagnosis of Schizophrenia.
- Some concern regarding ongoing agreement with oral medication although states he will take it on the ward. Team is planning to switch to depot.
- Risk of absconding/absent without approval (AWA) identified by Principal Service Provider (PSP). May abscond from hospital to pursue Steve (especially once informed he can no longer live with Rebecca).
- Ongoing delusions about Steve, gets angry when discussing Steve. Likely risk if Steve enters the ward.

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.

- Previously responded well to anti-psychotic medication and reported Valium or Xanax dampen down voices (treatment helps).
- Appears to be abstaining from cannabis and amphetamines.
- Supportive family (however can no longer reside with sister). Parents in Sydney, regular phone contact. Supportive sister in Brisbane.
- Can manage ADLs and finances independently when well.
- Completed high school achieving average to above average grades. Maintained friendships.
- Went to university, studied engineering (left early) then completed a course in hospitality with financial support of parents.
- Reported having friends through work, school in the past.
- Peter has had only a few periods of unemployment. Generally, works in hospitality e.g. cafes.
- Currently employed as a kitchen hand in a restaurant – reportedly gets along with restaurant staff and has a good work ethic.
- Peter has no criminal history, reportedly never shot a gun.

Luke's VRAM tool information gathering section

Queensland Government

Mental Health Services

Violence Risk Assessment and Management

Facility: Community CYMHS

(Affix identification label here)

URN:

Family name:

Given name(s): Luke

Address:

Date of birth: XX/XX/XX Sex: ☒ M ☐ F ☐ I

Mental Health Act status

☒ None recommendation ☐ Forensic order (mental health) ☐ Treatment support order ☐ Transfer

☐ 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:

☐ An interpreter was used

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

To identify the risk factors associated with recent serious physical violence at school, ongoing violence and aggression towards family members, as well as the strengths and protective factors which maintain stability for Luke.

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.

- 16yo male referred by school Guidance Officer (GO) following most recent suspension for a physical assault on another student at school.
- Current diagnosis of PTSD but no current medication. 1 previous episode of care with CYMHS age 9yo, differential diagnosis of PTSD and other negative events in childhood and emotional neglect of child. Risperidone 1mg age 9yo (? when self-ceased) and fluoxetine 20mg for 10wks age 9yo, poor adherence to fluoxetine. Query about autism spectrum disorder (ASD) traits however conceptualised in context of neglect.
- Exposed to domestic violence prior to his father's death when Luke was 3yo, Notifications to Child Safety in the past.
- Believes violence was justified 'didn't hit him (fellow student) that hard.' History of suspensions for aggression, disruptiveness, truancy. School report concerns about anxiety, communication problems, difficulty demonstrating empathic responses.
- History of aggression towards intellectually disabled 14yo sister and towards mother. This resulted in Luke living with uncle for 6mths recently where exposed to illicit substances use and query trauma.
- History of cannabis and cannabis use. Currently drinks alcohol intermittently with friends outside home.

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)

Physical violence at school recently. This resulted in suspension pending consideration of exclusion. Luke approached a fellow student, Tyson, from behind (so that Tyson would be unaware of his presence), punched him in the back of the head, and kicked him several times in the stomach once he had fallen down.

Luke then ran away before he thought any teachers would be able to catch him.

Tyson was unable to stand after the attack and had to be taken to hospital to ensure no lasting injuries. Luke reports this act was in response to Tyson 'looking at me funny' two days prior in the context of ongoing conflict/bullying. No remorse for actions.

Escalation in violence and aggression at school and home over past 6 months since return home from uncle's house, culminating in recent physical violence towards Tyson.

Ongoing reactive violence and aggression towards Jenny and Mindy. Jenny often required to intervene in altercations between Luke and Mindy, which can prompt aggression from Luke towards Jenny (including yelling and pushing/hitting). Luke viewed this as a reasonable response to 'annoying' and 'stupid' behaviour from others. Aggression also involved punching walls and slamming doors. Resulted in change to accommodation.

History of bullying towards sister. Would tease her, yell at her, and throw things at her/hit her if she did not do what he wanted. Luke viewed this as normal for sibling relationships. Jenny reports Mindy is often the target for Luke's aggression when frustrated with school or with Jenny.

History of ongoing bullying and intimidation of peers (especially vulnerable students and female peers), including verbal and physical aggression. Began in pre-school, escalated through primary school.

Suggestion from previous episode of care with CYMHS that Luke uses aggression to control his environment in order to manage anxiety.

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.

- Disrupted attachment.
- Exposure to domestic and family violence DFV – emotional abuse, substance use, family history of DFV.
- Stressful current family situation (single parent, disabled sister etc).
- Poor interaction with peers.
- Interpreting others behaviour towards him as threatening on the background of him being victimised/bullied.
- High levels of anxiety; managing this by using aggression to control the environment.
- Difficulty demonstrating empathic responses, lack of remorse, emerging attitudes supportive of violence.
- Communication problems, poor frustration tolerance, query ASD traits.
- History of impulsive and opportunistic (e.g. close proximity to Mindy) acts of violence and aggression.
- History of challenging behaviours including bullying, truancy, disruptiveness in class.
- Alcohol and other substance use.

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.

- Difficulty with limit setting.
- Requests from others (e.g. Jenny asking Luke to do something).
- High levels of anxiety and managing this by using aggression to control the environment.
- Conflict with peers/social problem solving.
- Hypervigilance.
- Impulsivity, aggression can be triggered by Mindy saying ‘stupid shit’.
- Availability of victim/opportunity (e.g. if student is isolated or Mindy being in close proximity/living together).

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

- Possible trauma reaction to incidents at uncle’s house.
- Possible modelling of dismissive/minimising attitude towards violence by Jenny.
- Jenny experiences difficulty implementing consistent behavioural consequences and boundaries. Increasing fear of Luke due to increasing strength and size.
- ?Numerous stressors detracting from Jenny’s resources to manage Luke’s behaviour (e.g. Jenny’s own mental health, Mindy’s intellectual impairment, pressure from school, family and financial stressors).
- Current alcohol use with peers. Approx. once weekly, approx. one third bottle of spirits. Denies drug use.
- Lack of remorse.
- Ongoing attitudes that support use of violence in certain situations.
- Lack of insight into triggers in escalation of own anger, and reactions of others in social situations.
- Lack of social problem solving (including emotion regulation and frustration tolerance).
- Hypervigilant to aggressive cues from others.
- Anxiety.
- Bullying by peers.
- Luke denied plan to harm others at school and intent to bring weapons to school, although acknowledged everyday items can be used as weapons.

Foreseeable changes

- Possible exclusion from school (currently suspended).
- Return to school from suspension and exposure to student he assaulted – possibility of exclusion if there is future violence.
- Potential breakdown in living situation/homelessness.

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.

- Luke is not an inpatient.

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.
• Likes school. • School referred/appropriately concerned. • Intelligent and has the ability to achieve high academic results at school. • Developmentally appropriate future focus (thinking about Uni, but not sure). • Enjoys gym and video games. • Mother and Luke's engagement with VRAM and CYMHS. • Remorseful about violence towards Mother.	

Peter's VRAM tool 5Ps

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

- Peter's 'menacing' behaviour towards his sister, Rebecca's boyfriend, Steve. Including accusations of Steve being a paedophile, hiding knives to defend Rebecca from Steve, and threats to harm/shoot Steve.
- Background of two significant violent assaults (1 month and 6 years ago), as well as pub fights in his 20s.
- The intensity of these incidents appears to be escalating over time.

Predisposing factors

- Trauma - sexual assault by a male school teacher in grade 10 – not disclosed/reported.
- History of perpetrating physical violence, commencing in his 20s.
- History of symptoms of schizophrenia which influence him to form suspicions about specific people (uncle and Steve), including:
  - grandiose delusions of having special powers and being chosen by the 'Illuminati' to receive information,
  - persecutory delusions of the 'Illuminati' identifying people who are a risk to others,
  - auditory hallucinations of the 'Illuminati' speaking to him, telling him who is 'bad' or 'a paedophile'.
- History of alcohol, cannabis, amphetamine and sedative use.

Precipitating factors

- Absence of treatment.
- Active psychosis (as outlined above).
- Exposure to people that Peter found annoying or thought were 'talking rubbish'.
- While in his 20s, intoxication combined with untreated psychosis seemed to be featured.

Perpetuating factors

- Ongoing hallucinations and delusions (both persecutory and grandiose).
- Associated poor judgement/psychotic reasoning that leads him to see violence as a legitimate way to protect Rebecca/mother.
- Lack of stable treatment for his psychotic symptoms.
- Limited insight.
- Homeless (he cannot return to his sister's).
- Potentially, use of substances (requires further assessment).

Protective factors

- Supportive family (close relationship with sister, regular phone contact with parents).
- Current employment, seem supportive. Only a few periods of unemployment.
- Previously responded well to anti-psychotic medication.
- Appears to be abstaining from cannabis and amphetamines.
- Can manage activities of daily living (ADLs) and finances independently when well.
- Completed high school achieving average to above average grades. Maintained friendships.
- Started university and went on to complete a course in hospitality.
- Nil criminal history.
- He has reportedly never shot a gun.

Luke's VRAM tool 5Ps

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

Physical violence towards students, mother and sister

Physically assaulted student (Tyson) recently in school yard when he was alone in the context of Luke being bullied/conflict two days prior. Tyson required hospital assessment.

Violence towards mother (Jenny) in the context of limit setting/him attempting to control the environment and 14 y/o sister (Mindy) with intellectual impairment in the context of her saying 'stupid things'.

Concerns over past 3 years, with violence at home and school escalating in frequency and severity over past 6 months.

Predisposing factors

- History of violence towards mother, sister and students.
- History running away from home and school, bullying others and targeting vulnerable students and female students.
- Diagnosed with post-traumatic stress disorder (PTSD).
- Exposure to domestic and family violence and father deceased when 3 y/o.
- Disrupted attachments and managing aggressive behaviours at home.
- Family stressors (financial, Mindy's intellectual impairment, Jenny's mental health).
- ?Trauma at uncle's.
- Reported (?perceived) history of being the victim of bullying at school.
- Attitudes that violence is acceptable in certain contexts.
- Limited/underdeveloped social skills.
- Difficulty demonstrating empathic responses.
- Poor frustration tolerance/emotion regulation.
- Hypervigilance to threat.

Precipitating factors

- Perceived slights against him (e.g. incident with Tyson).
- Opportunity/victim access.
- Poor frustration tolerance/emotional regulation.
- Bullying (against others and reported (?perceived) towards him).
- Need to control environment (heightened when feeling less in control of his environment).
- Peer conflict.
- Requests to initiate or cease an action/limit setting.
- Sense of injustice (from others, towards himself).
- ?Alcohol use.
- ?Poor sleep.

Perpetuating factors

- Limited/underdeveloped social skills.
- Poor insight into aggressive behaviours.
- Attitudes around violence (Luke's and other family members).
- Limited emotional regulation skills.
- Stressors (incl conflictual home environment, possible trauma event and response, and hypervigilance to threat).

- Ongoing peer conflict.
- Alcohol use.
- Anxiety (currently untreated), hypervigilance, sleep disturbance.
- ?Poor sleep.

Protective factors

- Intelligent and has the ability to achieve high academic results at school.
- Enjoys school.
- Developmentally appropriate future focus (thinking about Uni, but not sure).
- Enjoys/attends gym and enjoys video games.
- Luke and Mother (Jenny) engaged with CYMHS.
- Mother - attends to Luke's practical needs, displays concern and has a desire to support Luke.
- Remorseful about violence towards Mother.

Peter's VRAM tool high risk scenarios, early warnings signs, foreseeable changes

High risk scenarios

- Relapse of psychotic symptoms of the nature outlined above, together with disengagement from care and an absence of assertive management/treatment.
- Exposure to individuals that Peter finds annoying or who have been incorporated into his delusions, alcohol or other substance use, and/or a belief that authority figures are not doing enough to protect people Peter thinks are potential victims of harm.
- If Rebecca became pregnant to Steve and if Peter was unwell/became unwell, given Peter's statements while recently unwell that 'your boyfriend's a pervert, you can't have a baby with him'.

Early warning signs

- Talking about the 'Illuminati' and them having missions for him and/or telling him particular people are 'bad' or 'paedophiles'.
- Making accusations that people are harming others, asking if someone is hurting female family members or a paedophile, staring at people he is fixated on.
- Hiding weapons.
- Sending photos of evidence of perceived (delusional belief) harm.
- Calling the police to inform them of (unsubstantiated) harm by people incorporated into Peter's delusions e.g. Steve/Uncle Tim.

Foreseeable changes

- When informed he cannot return to live with his sister: if he is still experiencing the same symptoms, this stressful situation may feed into false belief/hallucinations about Steve (he may see him as the reason) and he may escalate due to this or to try to protect her.
- Rebecca possibly becoming pregnant (risk to Steve will increase if Peter still believes that Steve is a paedophile).
- Peter may leave, disengage and/or leave the state following discharge, given past behaviour.

Luke's VRAM tool high risk scenarios, early warnings signs, foreseeable changes

High risk scenarios

- High risk scenarios for Luke at school: Luke perceiving or misperceiving that others are talking about him/bullying him, conflict with students and students being alone without the supervision of others.
- High risk scenarios for Luke towards mother: Future situations in which Jenny sets limits or makes decisions about big things in Luke's life (e.g. where he lives) without including him.
- High risk scenarios for Luke towards sister: Future situations in which Luke is under increased stress, his mother is not responsive to this, Luke perceives that Mindy is saying lots of things that he perceives as 'stupid' and he is unable to manage his stress/frustration.

Early warning signs

Requires further assessment. Currently appears to include increased agitation, increased thoughts about perceptions of being mistreated, increased anxiety or sadness, and increased emotional arousal.

Foreseeable changes

- Expulsion from school (increase in personal and family stress).
- Return to school from suspension (increased access to victims, conflicts unresolved and bullying may continue).
- Less likely is a potential breakdown in living situation (homelessness) if violence to mother/sister continues.

Peter's VRAM tool victim group, probable nature of future violence, imminence of future violence

Victim group

Currently, the person at greatest risk appears to be Steve, as Peter has identified Steve as a target for aggression. However, more broadly, anybody incorporated into his persecutory delusional beliefs is at risk. Previously, this has been men and driven by delusional beliefs about protecting women (his mother/Rebecca) and children. Peter has reported that nobody else has been incorporated into his beliefs at present.

Probable nature of future violence

Peter has exhibited a pattern of escalation in his violence. Initially, he was participating in pub fights, he then punched a police officer in the chest, after which he punched his uncle several times in the head and was recently hiding knives in his room and threatening to shoot Steve. This pattern suggests that Peter's next episode of violence may be serious, and more likely to involve a weapon.

Imminence of future violence

In the hospital environment, Peter does not appear to be at imminent risk of future violence as no one there has been incorporated into his delusions. He is also regularly monitored in this environment, including for symptoms, medication adherence, and access to substances. He has limited access to weapons, and he does not have access to Steve in hospital. As Peter continues to experience delusional beliefs and given many of the precipitating and perpetuating factors are still present he may be at imminent risk of further violence if he were to leave hospital.

Luke's VRAM tool victim group, probable nature of future violence, imminence of future violence

Victim group

While Luke is suspended, his most likely victim is Mindy, followed closely by Jenny. Beyond this, upon return to school Tyson (if matters are not mediated) and other students who are perceived by Luke to be treating him unfairly have the potential to become victims.

Probable nature of future violence

Luke's most recent violent episode was severe in nature, resulting in his victim being unable to stand and requiring a physical assessment at hospital. While he denies any plan or intent to use a weapon, it is possible he may do this spontaneously. Additionally, Luke is large for his age and is physically strong. As such, he may be capable of inflicting serious damage in a physical altercation, especially to people smaller than him or females.

Imminence of future violence

Given Luke's access to potential victims (especially Mindy), the commonplace nature of his high-risk scenarios, and the current high-stress context (currently suspended with possibility of expulsion), his next episode of aggression may occur soon.

Peter's VRAM tool risk status/risk state

Risk status

Currently, Peter's risk of violence is higher than others accessing care in an inpatient setting as he has ongoing active psychosis incorporating an identified victim (Steve), made threats towards this victim, and has been hiding weapons in anticipation of an altercation with this victim. He has limited insight into his need for treatment (including medication) and requires ongoing close monitoring and restriction of leave to manage his risk.

Risk state

Peter's current level of risk is higher than when he beat his uncle one month ago because he continues to display similar symptoms (i.e. persecutory delusions and hallucinations about a specified victim), he has now begun hiding weapons and because previous incidents of violence have been in the context of symptoms of psychosis.

Luke's VRAM tool risk status/risk state

Risk status

Currently, Luke's risk of violence is higher than that of most consumers within the Child and Youth Mental Health Service, due to his recent severe violent episode, lack of remorse, emerging violent attitudes, and lack of insight into his violence; in combination with a stressful home environment that does not provide clear and consistent behavioural consequences and boundaries.

His risk of violence is lower than inpatients of an adolescent unit as he is not experiencing symptoms of psychosis and he does not have active plans to harm others.

Risk state

Luke's risk state currently appears to be slightly lower than when he attacked Tyson as he currently has reported no specific conflict with any peers and is suspended. However, his risk state is higher than when he commenced his stay with his uncle 12 months ago due to escalating aggression and likely trauma experienced during this stay.

Peter's prevention oriented risk management plan

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**
Disengagement from care/treatment	Long term meaningful care	Maintain an assertive, trauma informed and compassionate based engagement approach with Peter and family. Consider using a motivational interviewing approach and psychoeducation to increase insight into the need for engagement. Ongoing daily serial Mental State Examinations (MSEs) and risk screens while on the inpatient unit, reconsider frequency on discharge.
Active symptoms of psychosis	Manage symptoms	Ongoing assertive longer term case management. Treatment with anti-psychotic medication. Consider depot long term to aid adherence. Regular medical reviews. Monitor responsiveness/side effects via serial medical/MSE/risk reviews.
	Monitoring who is incorporated into delusions	Ensure treating team (including all nursing staff) are aware of Peter's delusions. Staff to enquire about incorporation of others into delusions and update CIMHA alerts as required.
	Maintain adherence to treatment	Manage under Treatment Authority as needed. Assign long-term community case manager. Psychoeducation when Peter's mental state is appropriate. Motivational enhancement approach to medication adherence supported by clear understanding of his specific concerns relating to medication.
	Increase insight	Provide psychoeducation around illness, violence and relapse prevention/management. Consider Cognitive Behavioural Therapy (CBT) for psychosis.
	Reduce vulnerability	Complete a Police Advice and Intervention Plan (PAIP) to share relevant clinical history ahead of further possible police complaints to flag that this indicates mental state deterioration and that he needs to be linked with Mental Health Alcohol and Other Drugs Services (MHAODS).
Homelessness	Find residence for Peter	Work with Peter, relevant Non-Government Organisations (NGOs) and Department of Housing (DOH) to find a place to live prior to discharge. Referral to long term Case Management (adult mental health or suitable NGO) to support independent living.
	Inform Peter of inability to live with Rebecca in a manner which protects social relationships	Once Peter's insight improves and in a safe setting to manage escalations, have an experienced staff member Peter trusts inform him of Rebecca's decision. Engage in psychoeducation around the reasons. Continue ongoing close monitoring over the coming days/weeks. Ensure Peter understands that the service has found/is finding alternative living arrangements prior to discharge.
Risk to Steve	Reduce weapon seeking and access to weapons	Treat psychosis, restrict access to knives and other weapons, regularly check Peter's areas for hidden weapons. Complete a weapons licensing notification to Queensland Police Service (QPS) (https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health), confirm receipt, document in CIMHA and add alert.

Risk to Steve (cont'd)	Treating team to take steps to protect Steve wherever possible	Discuss with the domestic and family violence (DFV) Coordinator (Contacts and referrals | Queensland Health Intranet) to consider the need for referral as well as advice around victim safety planning. Undertake victim safety planning with Rebecca and Steve based on the DFV coordinator's specialist advice around this, e.g. ensuring Steve knows to retreat to a safe place if Peter approaches and call Triple Zero. Update Steve with advice as the risks resolve. Offer linkage with specialist victim support services. Have a high-risk absent without approval (AWA) plan in place re: reporting to QPS via Triple Zero, who can warn Steve or seek legal advice to determine if the treating team need to do this. Ensure all members of Peter's treating team are aware of the risk to Steve, and what behaviours are likely to aggravate these (e.g. accidental collusion with delusional beliefs, Steve visiting the ward). Close monitoring of symptoms related to Steve. All CIMHA alerts have been added and will be updated as required.
Substance use	Minimise harmful use of alcohol, cannabis and methamphetamines	Overarching harm reduction and motivational enhancement approach. Thorough assessment of substance use, including identification of function of use, possible cues and consideration of alternative behavioural strategies. Develop plan for continuing assessment including by urine drug screen (UDS) which is random but targeting likely times of use in a way that he agrees may support harm minimisation.
Poor frustration tolerance	Enhance non-violence based problem solving	Problem solving skills for managing potential threats to the safety of others, CBT for psychosis and ?cognitions around people who 'talk rubbish' and impact on perceived risk, establish consequences for engaging in violent behaviour.
Incomplete information	Gather further collateral	Gather collateral from NSW Health (if he was seen by them) and the Mental Health Intervention Coordinator. Discuss at multidisciplinary team (MDT) meeting and update risk screen, alerts and other forms as required.

Peter's protective factors

Protective factors	Clinical goal	Preventative strategies, interventions and involvement of other service providers
Family support	Maintain and enhance family members' ability to support Peter	Hold family meeting with treating team, Rebecca and Peter's parents (with his consent and via phone). Provide education regarding Peter's symptoms, early warning signs and risks; as well as information about treatment (including rationale), and ongoing management. Brainstorm a plan for likely upcoming challenges, and approaches for managing these.
Current employment	Maintain employment	Discuss potential impact of time away from job with Peter and family. If desired, provide supportive letter to employer explaining absence. If desired, hold meeting with employer to support ongoing employment.

This assessment is informed by: (note engagement with consumer, and sources of collateral)
CIMHA records – alerts, transfer of care on XX/XX/XXXX and general assessment on XX/XX/XXXX. Interview with Peter on XX/XX/XXXX. Discussion with Mary Nightingale (Peter's PSP). Phone interview with Rebecca (Peter's sister).
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)
This report will be discussed by the PSP with Peter's treating team at care review tomorrow, XX/XX/XXXX and the risk management plan will be included in his Care Plan. Information to be shared with Steve, Rebecca, and Peter's parents regarding Peter's symptoms, risks to family's safety, treatment and rationale, safety plan, and resources to maintain own mental health. Information about treatment to be shared with Peter, and his input to be incorporated into risk management plan.

Luke's prevention oriented risk management plan

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**
Absence of professional services	Ongoing close monitoring and coordination of services	Provide ongoing case management, adopting a trauma informed and compassionate based engagement approach with Luke and Jenny to promote long-term meaningful engagement in care. Maintain regular contact with Luke and family. Weekly face to face sessions, including serial risk screens and Mental State Examinations (MSEs) with Principal Service Provider (PSP). Monthly medical/consultant reviews. Conduct regular stakeholder meetings (between CYMHS PSP, Luke, Jenny, school) to identify changes in risk profile, including foreseeable changes (e.g. return to school) and to agree management strategies. PSP to link school with Ed-LinQ coordinator to provide consultation liaison, mental health and wellbeing training and education to school staff and enhance and enable communication between school and CYMHS. PSP to maintain up to date CIMHA alerts.
Ongoing access to (previous victims) Tyson, Mindy and Jenny	Reduce risks to victims	Discuss with the domestic and family violence (DFV) Coordinator (Contacts and referrals | Queensland Health Intranet) to consider the need for referral as well as advice around victim safety planning for Mindy and Jenny. Monitor through regular reviews with Luke and ongoing collateral from Jenny, Luke's early warning signs (EWS), triggers, stress/coping, foreseeable changes. Provide psychoeducation around EWS and triggers on an ongoing basis. If able to return to school: Luke, Jenny, PSP and Guidance Officer (GO) to develop a school EWS plan prior. Consider graduated return and a return to school plan generated by Luke, family, PSP and key school stakeholders that will include increased monitoring at start, victim safety planning/support for Tyson and if safe, conflict resolution/mediation between Tyson/Luke. Work on strategies with Luke to manage crises with Mindy/Jenny. Develop a detailed victim safety plan with Jenny to ensure safety of herself and Mindy (e.g. early intervention, setting boundaries safely, calling the police if required) within 2 weeks. Discuss plan with Mindy (if appropriate or have Jenny discuss) re how to alert Jenny to threats to her safety. PSP to monitor for requirement for notification of concern to Child Safety.
Unclear diagnostic picture	Clarify diagnoses e.g. ASD, anxiety, PTSD	Luke, family and CYMHS treating team (including consultant psychiatrist, registrar and PSP) to undertake a broad diagnostic assessment, provide recommendations for care, discuss with Luke and incorporate into Care Plan.

Trauma reactions and emotional regulation	Enhance Luke's ability to tolerate anxiety, a sense of injustice and/or frustration when others behave in ways he finds triggering	Treating team to focus on building a trauma informed therapeutic alliance with Luke, provide psychoeducation to Luke around trauma, discuss and practice strategies for managing symptoms/trauma responses i.e. sensory strategies for anxiety. Establish a plan with Luke for self-managing conflict at school and home when triggered by anxiety/fear (e.g. identifying safe place to go, identifying safe person to talk to prior to becoming aggressive, sensory approaches to emotional regulation). Ensure this plan is also communicated with key school stakeholders.
Living situation/family relationships	Improve attachments and anxiety management by encouraging more structure in the home and support Jenny	Ongoing supportive counselling/problem-solving and psychoeducation with Jenny by PSP regarding how to deliver requests in a manner which is likely to maximise the chance of a positive response. Consider attachment-based therapy with Luke, family therapy and also parenting skills programs (Circle of Security, Triple P). PSP to provide information around same (within next 91 days) to support informed choice. Provide information for services to maintain Jenny's mental health (e.g. Arafmi (support for mental health carers), Mental Health Care Plan (MHCP)) and carer support services (esp. for Mindy) and financial planning support through Non-Government Organisations (NGOs).
Lack of insight into violence	Enhance insight	PSP to initially focus with Luke and family on rapport building, psychoeducation (e.g. shared collaborative formulation), work around early warning signs, triggers, what maintains behaviours (e.g. chain analysis) and adaptive coping responses.
Emerging violent attitudes	Work on emerging beliefs that violence is acceptable	PSP to commence cognitive behavioural therapy (CBT) and compassion focused therapy to foster victim empathy/perspective taking, cost/benefit analyses including discussing personal consequences of violence (e.g. legal, time, mental health, education, relationship impacts), target emerging core beliefs and identify strategies to manage self-talk around violence. PSP to consider CBT to further enhance insight/self-awareness if needed after above strategies under 'enhance insight' goal is implemented.
Social interaction/communication skills	Enhance social skills	PSP to explore with Luke referral to social skills groups (if available) within 1 month. Case management sessions to include interventions targeting communication and social problem solving.
Alcohol use	Minimise harms from alcohol	PSP to monitor substance use and to work with Luke using motivational interviewing, psychoeducation and identify cues and functions of alcohol use, and collaboratively plan strategies for harm minimisation.

Luke's protective factors

Protective factors	Clinical goal	Preventive strategies, interventions and involvement of other service providers
Engaged in school	Maintain engagement at school	CYMHS to develop collaborative relationship between Luke and key school staff, collaborate with school to set up adaptive coping strategies for Luke (e.g. safe people and places to go to when he gets angry). PSP to link school with Ed-LinQ coordinator to support. See above under 'Ongoing close monitoring and coordination of services' clinical goal and strategies.
Engagement with CYMHS	Maintain engagement	Continue to provide assertive, trauma informed and person-centred care. Take into consideration Luke's preferences and strengths.
Good use of spare time (gym and video games)	Maintain physical health, establish adaptive and safe ways to regulate aggression	PSP to encourage continued engagement with gym, consider engagement with mentor who can teach Luke to express aggression safely and adaptively (e.g. martial arts teacher, football coach). If required, PSP to explore financially sustainable gym options for Luke. PSP to incorporate video games into plan for alternative coping strategies for managing violence risk.
Strong attachments and bonds	Maintain relationships with family/living situation	CYMHS treating team to work in a collaborative and supportive manner with mother, as well as provide linkage with professional supports as outlined throughout this plan.

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

- Jenny (Mother)
- School guidance officer (Virginia)
- CIMHA – all clinical records
- Interview with Luke.

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)

- The VRAM report was developed with ongoing discussion and consultation with Luke's PSP and treating psychiatrist and formally presented at the Care Review Meeting on XX/XX/XXXX.
- The contents of the report was explored with Luke and Jenny on XX/XX/XXXX.
- Consent was obtained for relevant information to be explored at the upcoming stakeholders meeting with Luke, Jenny and School on XX/XX/XXXX.
- The PSP has agreed to incorporate all relevant information in the Care Plan for Luke.

Practice support resources

RESOURCE	DESCRIPTION	QR CODE
VRAM Tool Tipsheet	Provides tips for reviewing files, detailed descriptions of what to cover when gathering information, and key considerations for both formulating violence and developing prevention-oriented violence risk management plans.	
Question Bank for Violence	A standalone question bank containing a range of example questions for assessing different types of violence that can be tailored to the individual.	
Collateral Gathering for Violence	Designed to support the safe gathering of collateral information from family, carers, Kin and significant personal supports (who may have been victims of violence). Provides a range of processes and example questions that can be tailored to the individual situation.	
Adult Strategies for Managing Violence	Provides a range of strategies that may be useful when creating an individualised plan to manage violence risk in adults. This resource can also be used as a checklist or audit tool when developing Violence Risk Assessment and Management (VRAM) plans, having conversations with the Multidisciplinary Team (MDT) or Assessment and Risk Management Committee (ARMC), or during clinical supervision.	
Child and Youth Strategies for Managing Violence	Provides a range of strategies that may be useful when creating an individualised plan to manage violence risk in children and young people. Similar to the adult strategies, this resource can also be used as a checklist or audit tool when developing Violence Risk Assessment and Management (VRAM) plans, having conversations with the Multidisciplinary Team (MDT) or Assessment and Risk Management Committee (ARMC), or during clinical supervision.	

VRAM tool tipsheet

Aim: This resource focuses on providing **tips for reviewing files** and **what to cover in each section** of the Violence Risk Assessment and Management (VRAM) tool.

Links to other resources: You may use this tip sheet in conjunction with the Question Bank for Violence and Collateral Gathering for Violence. You may find it helpful to review the Violence Risk Assessment and Management - Comprehensive Care Documentation Guide | Clinical Excellence Queensland.

Key considerations

- When gathering data for a Tier 2 assessment ideally you will need to do a thorough *file review*, *talk to the person* and *gather collateral* from a range of sources.
- Similar to any domain of risk, or assessment process, cultural factors should always be explored and considered when completing a Tier 2 assessment.

File review tips

A **file review** is a good place to start a Tier 2 assessment to support a comprehensive understanding of the person and risks. It will help identify unknowns and guide where further clarification with the person and/or collateral information is needed. It can help to identify 'where to next' when gathering information.

- Start a draft VRAM tool template in the electronic record at the point of referral or during the Care Review/multidisciplinary team (MDT) discussion.
- Use the file review to populate the form with as much data as you can, including risk-increasing factors and protective factors that are relevant for the person.
- Sometimes similar information will need to go in a few boxes. Be guided by the subheadings (dot points).
- Review multiple health/incident databases e.g. CIMHA, ieMR, The Viewer, paper files, PRIME (risk management software).
- Using key word search and report functions can save time.
- If you are short on time, a selected file review may be the first step. Focus on reviewing the following documents and reading the notes surrounding any critical dates.

- ☐ Comprehensive assessments
- ☐ Longitudinal summary
- ☐ Risk screens
- ☐ Alerts (active and ended)
- ☐ Past VRAM tools
- ☐ Medical reviews
- ☐ Admission notes
- ☐ Transfer of care
- ☐ Care review summaries
- ☐ Past episodes of care, including admissions/why
- ☐ Domestic and family violence (DFV) Common Risk and Safety Framework (CRASF) and victim safety planning tools
- ☐ Mental Health Review Tribunal clinical reports
- ☐ ARMC minutes
- ☐ Involuntary patient and voluntary high risk patient summary
- ☐ The forensic dossier (Forensic Orders only)
- ☐ Tier 3 risk assessment reports/notes (i.e. Community Forensic Outreach Service (CFOS) or Forensic Child and Youth Mental Health (CYMHS) or Queensland Fixated Threat Assessment Centre (QFTAC))
- ☐ Discipline specific reports e.g. occupational therapy, psychology
- ☐ Mental health child protection form
- ☐ Acute management plan (AMP)
- ☐ Police advice and intervention plan (PAIP)
- ☐ Information under the Mental Health Act (MHA) tab (e.g. Mental Health Act (MHA) status, Emergency Examination Authorities (EEAs), psychiatrist reports)
- ☐ Positive Behaviour Support Plan (PBSP)
- ☐ Queensland Police Service (QPS) information (e.g. criminal history or details of domestic violence orders DVOs)

Filling out the VRAM tool

Remember to: *Review the file, talk to the person and gather collateral to complete the VRAM tool.*

Queensland Government

Mental Health Services Violence Risk Assessment and Management

Facility:
Date: Time:

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: 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:

An interpreter was used

Purpose of assessment

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

Document:

- The main behaviours of concern, noting the VRAM tool can be used for physical violence, threats of harm, DFV, stalking, fire setting or sexually harmful behaviours.
- The presence of high-risk psychotic symptoms (e.g. command auditory hallucinations, delusional jealousy).
- The rationale/reason the VRAM tool was recommended for this person at the MDT/Care Review.

Definition of violence provided in the ARV Framework (2026):

"A broad range of behaviours, actual, attempted, or threatened, that cause or are intended to cause physical, psychological, emotional, or sexual harm to a person, including harm directed toward oneself, or damage to property."

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.

This section is designed to provide a greater understanding of the person and their history, not all information here will be directly about violence.

Document:

- the reason for referral to mental health services and information around past episodes of care
- information pertaining to the above dot points (i.e. age, diagnosis etc.).

Risk history:

- ensure under risk history that you capture all risk domains from the risk screen including historical and acute risk e.g. suicidality.

Consumer's previous violence/other problem behaviours and the context in which they occurred

(Note first known violence, and any pattern, increasing frequency or severity of harm, evidence of weapon use and details regarding previous victims, including domestic and family violence)

Provide a detailed account of the person's previous violence/problem behaviours from first known through to the most recent episode.

Document specific details <u>for each event</u> by addressing the following:

- the context in which the violence was occurring (e.g. bullying, homelessness, DFV, mental illness)
- predisposing and precipitating factors for the violence
- known early warning signs
- targets of violence
- severity of the past violence
- use of **weapons***, as well as how they were used and how they were obtained.
- the mental state of the person at the time.

***Weapons** can be everyday items e.g. chairs, kitchen knives and/or legal/illegal items e.g. [registered] firearms, crossbows, 3D printed guns, paintball guns, martial arts equipment, explosives, bombs.

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

Document **violence related factors that are historical** in nature and unable to or slow to change. Consider and articulate any known intergenerational factors (e.g. substance use, domestic and family violence, community violence).

Examples:

Violence:

- nature (e.g. sexual violence, stalking, domestic and family violence)
- towards whom or what
- threats
- when.

What was happening for the person at the time (e.g. mental state).

Problematic substance use:

- type of substance(s) used (e.g. methamphetamine, alcohol, prescription medication)
- frequency, amount and duration of use.

If known, impact on functioning (e.g. work, relationships, violence, antisocial behaviours).

Pro violence attitudes:

- stable beliefs that violence is acceptable and any known context around this (e.g. justified in certain culturally normalised oppression and violent behaviour, or circumstances or towards certain people, core family belief/value system).

Personality disorders:

- any known diagnoses.

Antisocial behaviour:

- describe the behaviours i.e. illegal acts, acts directed at people (e.g. bullying), property damage
- include any information on what might be driving this behaviour (e.g. manic episodes, peer influences).

Other mental disorders:

- diagnosed mental health disorders (e.g. depression, bipolar affective disorder, schizophrenia)
- neurodevelopmental disorders (e.g. autism, intellectual disability, attention deficit and hyperactivity disorder)
- neurocognitive and neurodegenerative disorders (e.g. dementia).

Relationships: (i.e. family, friendships, romantic relationships) • conflict • unhealthy dynamics • inappropriate intensity or superficiality • domestic and family violence • absence of relationships. **Note:** Positive relationships can be noted in protective factors as appropriate.	**Traumatic experiences:** • traumatic experiences across the lifespan • symptoms of trauma • links between trauma and violence (e.g. consider intergenerational factors).
Employment (Includes paid work, study and voluntary work) Comment on: • stability of employment • any known dismissals/warnings/complaints • poor attendance • inability to work for any reason (e.g. physical injury, mental health and wellbeing). **Note:** History of stable employment/study can be noted in protective factors.	**Treatment adherence and response to treatment:** • engagement with service/attendance at appointments • adherence to medication • efficacy/responsiveness to medication • engagement/response to therapeutic interventions (e.g. cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), attachment-based therapy, medications). **Note:** History of positive engagement, adherence and treatment response can be noted in protective factors.
For **child and youth**, also consider	
Peer group/influences: • association with violent peers or gangs may contribute to a young person's violent behaviour • comment on any negative or challenging peer influences and the nature and impact of these (e.g. bullying and harassment, engaging in violent acts with other young people). **Note:** Positive peer influences can be noted in protective factors.	**School achievement/engagement:** • school absenteeism (e.g. truancy, school refusal) • level of engagement when at school • known punitive actions (e.g. suspension, exclusion) • academic performance. **Note:** Positive school engagement and achievement can be noted in protective factors.

Dynamic factors that precipitated previous violence

Consider:

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

Child and youth also consider:

- Peer influence

Document factors that **triggered (precipitated) episodes of violence in the past**. Consider if the below examples were triggers for past episodes of violence:

Examples:

Insight
If a trigger, comment on level of awareness at the time of past violence:

- of own mental illness and symptoms
- of violent behaviour
- of triggers for the violent behaviour.

Living situation

- Comment on any aspects of the person's living situation that contributed to past incidents of violence, e.g. stability of housing, safety of housing and neighbourhood, homelessness, overcrowding, where they live (e.g. residential care) or who they live with.
- If any people they live with have been/are incorporated into their symptoms or identified as past victims or possible victims.

Violent ideation
Was the person experiencing any thoughts, plans, desires or fantasies to harm others at the time of past violence? If so, comment on:

- nature of the ideation
- frequency of the ideation
- strength of intent to act
- any plans to act
- the person's reactions and responses to these ideations
- the person's thoughts about other people's intentions to harm them or others.

Social situation
Comment on any aspects of the person's social situation that contributed to past violence incidents, such as:

- nature of relationships (e.g. with friends, family, partner, colleagues)
- ruptures or conflicts
- lack of social supports
- disconnection or limited connection to family, community, culture and spirituality.

Symptoms of major mental disorder
Were symptoms of a major mental disorder triggering past episodes of violence? If so, comment on:

- nature of symptoms
- how they related to/drove the violence
- diagnoses/disorders driving the symptomatology.

Stress/coping

- Comment on stressors that were beyond the person's ability to cope at the time of previous violence (e.g. relationship breakdown, peer conflict, parental separation, lack of safe parental/kinship care givers, financial stress, job loss).
- Comment on how the person was coping with these things (if known) e.g. bottling up stress/anger and becoming verbally abusive.
- Stress associated with physical comorbidities and/or physical pain.

Problematic substance use
Was substance use a trigger for past violence? If so, comment on:

- type of substance(s) used
- frequency, amount and duration of use
- if known, impact on functioning (e.g. work, relationships, violence).

Anger
Was the person experiencing elevated levels of anger at the time of previous violence? For example:

- having a 'short temper'
- increased aggression (e.g. verbal)
- increased threats
- increased psychomotor activity/agitation
- menacing body language.

Treatment adherence and response to treatment Was this a trigger for past violence? If so, comment on: • the type of treatment • reasons for non-adherence if known. • consider responsiveness to treatment e.g. treatment resistance.	**Impulsivity** Was the person displaying any signs of impulsivity at the time of previous violence? For example: • making sudden decisions with little forethought • making reckless decisions/actions • not weighing up/considering consequences to actions.
For **child and youth**, also consider	
Peer group/influences • Was association with violent peers or gangs contributing to a young person's past violent behaviour? • Comment on any negative or challenging peer influences and the nature and impact of these (e.g. bullying and harassment, engaging in violent acts with other young people).	

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

Dynamic factors that contribute to current and future risk. Dynamic factors are changeable factors that **currently increase violence risk**.

- A current **mental state examination** (MSE) of the person at the time of the VRAM interview will assist in completing this section.
- It is likely many of the factors identified in previous sections of the VRAM tool will be contributing to the current violence (or at play very close to the time of assessment). Document these here and any dynamic factors that are likely to contribute to future risk.

Foreseeable changes that could quickly increase risk. Document specific **upcoming events that will likely increase violence risk** in the near future. For example:

- upcoming court hearings
- divorce settlements
- the person's long-term principal support person (PSP) going on extended leave
- moving to a new school.

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

Only complete this section if the person is a current inpatient.

Document risk factors unique to the **inpatient environment which are likely to impact the person's violence risk**. A current **mental state examination** of the person at the time of the VRAM interview will assist in completing this section.

Examples:

Confused/over excited behaviour: • high energy • loud/boisterous • insistent and/or intrusive • difficulty understanding and orienting to surroundings.	**Physically/verbally threatening/property damage:** • threats to harm others • encroaching on others' personal space • aggressive posturing and mannerisms (e.g. raise fists, glaring) • aggressively touching others (e.g. pushing, barging, hitting, grabbing others' clothing) • property damage (e.g. throwing objects, kicking/punching property, breaking furniture).

Irritable/sensitive to provocation: • in the context of relatively mild stimuli can become easily/quickly: – overwhelmed – annoyed – angered. • reacts aggressively to perceived provocation, slights or insults.	**Impulsivity**: • if the person is displaying any signs of impulsivity during their admission, note this and its impact on violence risk in the inpatient environment.
Unwilling to follow directions/angered when requests are denied: • choice to not comply with reasonable directions (e.g. ignoring, arguing) • becoming angry or aggressive when: – requests are denied (e.g. leave) – requests are made of them (e.g. to turn down the volume of the TV).	**Other areas of consideration:** • a desire not to be admitted • conflict with other patients • disagreement with treating team recommendations • preoccupation with, or lack of access to, events occurring outside the unit (e.g. family and community deaths, sad news/sorry business).

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

Document factors that **reduce the likelihood of a person engaging in violent behaviour**, as well as those that the person can use to increase their resilience. Protective factors need to be:
- **accessible** - there are no/minimal barriers to accessing the resource/strategies. It can be reached or used (e.g. the person has money to take the bus to the clinic)
- **available** - the resource/strategies are readily available
- **valued** by the person (e.g. the person is willing to try the strategy)

Examples:

Treatment adherence and response to treatment: • stable engagement and adherence in any therapeutic interventions (e.g. cognitive behavioral therapy, attachment-based therapy, medications) • interventions that are currently effective.	**Relationships/supports** Comment on: • how these embody supportive, adaptive and healthy behaviours • any positive relationships with friends/family/kin/key others (e.g. teacher, sports coach, work mentor) • if linked into/engaged with community supports and/or programs (e.g. social clubs, sports, church, General Practitioner (GP), National Disability Insurance Scheme (NDIS), youth justice).
Coping/social skills Current skills the person possesses as well as how/whether they're utilised, for example: • problem solving • managing conflict • strong cultural identity • help seeking • adaptively managing emotional distress.	**Available resources:** • note any *available* resources (e.g. able to get in touch with Indigenous support service Monday – Thursday between 9am and 4pm or can be utilised at any time e.g. 24/7 helpline) • support via My Aged Care (e.g. supervision of medication, transport, activities of daily living [ADLs]) • support via NDIS.

Stable living situation: • the person has stable accommodation • the person gets along with the people they live with.	**Insight/awareness of triggers:** • able to identify triggers for past violent behaviours • has strategies developed to cope when triggered - note if actively uses these • understands impact of violence on self or others • willingness to learn new skills or build upon existing ones.
Stable mental/emotional state: • asymptomatic • ability to regulate emotions • ability to understand and cope with symptoms should they arise/resilience.	**Meaningful time use:** • engages in activities that provide a meaning and purpose (e.g. paid work, study, hobbies, interests, volunteering, cultural activities, socialising - consider online or in person)
For **child and youth**, also consider	
Peer relationships, supports and activities: • engaged with peers or other supports that are positive influences • engaged in adaptive activities that provide a sense of belonging, connection, joy.	

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.

Explain why violence risk is occurring for the person at the time of the presentation by integrating and explaining identified violence risk factors (not simply re-stating them). No new information should be introduced in the summary.

Include the following in the **violence risk summary (formulation):**

The 5 P's

- **Presenting problem:** Specific violent behaviours you are formulating to. Keep this brief and concise.
- **Predisposing:** Factors that make a person more vulnerable to the behaviours outlined in the presenting problem.
- **Precipitating:** Factors that trigger the behaviours outlined in the presenting problem.
- **Perpetuating:** Factors that prevent the presenting behaviours from resolving without intervention.
- **Protective:** Factors that reduce and mitigate the presenting behaviours.

High-risk scenarios: A set of circumstances that, should they occur, are likely to increase risk of violence and aggression e.g. relapse to using meth, financial stressors, drug induced psychosis, Child Safety intervention, partner leaving might increase risk of the person returning to stalking ex-partner.

Early warning signs: Thoughts, feelings, symptoms and behaviors that indicate an increased/increasing risk of aggression and violence risk e.g. increased violent ideation, increased preoccupation with delusions.

Foreseeable changes: Specific events occurring in the future which will likely increase risk of aggression and violence e.g. partner seeking full custody and they are likely to get it following the next court hearing.

Victim group: Potential victims of future violence e.g. family member, partner, school staff, students, children.

Probable nature of future violence: Consider the types of past violence. Are there patterns? Is there escalation? What were the victim impacts of the violence?

Hint: Compare current context/dynamic risk factors to past violence and context/dynamic risk factors that were present at the time of previous violence.

Imminence of future violence: How soon is the violence likely to occur?

Hint: Consider factors such as mental state, intoxication, access to weapons, escalation and environment (e.g.

community vs inpatient).

Risk status: The person's current risk of violence compared to others in your service setting. NB: comparison to general population is not required.

Risk state: The person's risk of violence compared to significant time points or events in their life.

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.

This section of the VRAM tool tipsheet is recommended to be used in conjunction with the Adult Strategies for Managing Violence or the Child and Youth Strategies for Managing Violence.

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**
List **identified risk factors** that are relevant to the person and require intervention to reduce the risk. Every identified risk factor needs to be listed/addressed. If there is unknown/missing information, include this as a risk factor and identify goals and strategies to address this risk.	**What** are we going to do? For each risk factor, document a goal that intervention aims to achieve.	**How** are we going to do it? Consider **recovery orientated** principles and approaches. Make them **SMART** for example: • list one or more **specific** strategies • list in a stepwise manner • document who is proposed to carry tasks out and estimated dates for review or completion dates.
Example: Access to weapons (E.g. The person reported they currently have a crossbow, chainsaw, 3D printed gun and registered firearm at home).	Reduce access to means	By (date), PSP to: • For any future imminent or urgent safety concerns about someone's behaviour or access to a weapon, call Triple Zero (000). • Complete the Weapons Notification form and email this to QPS. • Contact QPS to establish when they will be able to remove weapons and/or if they can confirm this has happened e.g. if the consumer is being discharged. • Upload Weapons Notification form and email into the clinical record (CIMHA/ieMR). • Review/update CIMHA/ieMR/Viewer alerts if required. Person, treating team and PSP to, by (date): • Work with the person to develop insight into the risks to themselves and others of having access to weapons. • Assist the person to address emotional regulation, decision-making and attitudes that influenced them to obtain weapons using CBT, sensory approaches and by developing a violence safety plan.

Example: Homelessness	To find suitable and stable accommodation	Person and PSP to, by (date): • Support the person to do some problem solving around options for housing • Explore short/long term options for housing • Explore/support them with referrals for housing • Follow up assertively every two weeks as to the progress referrals.
Protective factors	**Clinical goal**	**Preventive strategies, interventions and involvement of other service providers**
List **identified protective factors** that are targets for intervention	**What** are we going to do? • for each protective factor, list a goal that treatment aims to achieve • goals can be designed to maintain or enhance a protective factor	**How** are we going to do it? Make them SMART for example: • list one or more **specific** strategies designed to achieve the clinical goal • list in a stepwise manner • document who is proposed to carry tasks out, and estimated dates for review or completion dates.
Example: Family/carers engaged	Maintain personal supports	Person, family/kin/carers, external services, person to, by (date): • Maintain strong attachment/bonds where possible by involving the family (with consent). • Regularly follow up with parents/kin/carers to check in, identify support needs and respond. • Support parents/carers with their mental health, carer stress and link with services to avoid burnout e.g. Arafmi, COPMI, Emerging Minds, Carer Gateway, GP for a Mental Health Care Plan (MHCP).

This assessment is informed by

(Note engagement with consumer, and sources of collateral)

List all the sources that you obtained information from. Where possible, also include the date and mode through which you obtained this information (e.g. telephone call on XX/XX/XXXX, face-to-face interview on XX/XX/XXXX).

Potential sources of information include:

- CIMHA
- ieMR
- Viewer
- CRASF
- Person interview
- The person's partner
- Family/kin
- Aboriginal and Torres Islander Health Worker, Practitioner, and/or Hospital Liaison Officer
- Multicultural Mental Health Coordinator
- Mental Health Intervention Coordinator (MHIC) or QPS (criminal history, details of DVOs)
- Positive Behaviour Support Plan (PBSP)
- NDIS providers
- My Aged Care Service providers
- Friends
- Employer
- School personnel
- General practitioner
- Child Safety/Youth Justice staff
- Probation/parole reports.

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)

It is important to consider the needs of family, carers, support people, and potential victims when safety planning and distributing risk related information.

Document:

- the people who were provided with information and any further interventions provided in relation to this (e.g. conducting victim safety planning, linkage with carer support services)
- what information was provided (e.g. VRAM findings, recommendations, safety plans)
- the date and mode of delivery (e.g. face-to-face, telephone)
- the recipient's understanding of the information they were given.

Please Note: Once finalised, the Assessing and Responding to Violence (ARV) Framework outlines that the violence risk summary and risk management plan generated within the VRAM tool must be incorporated into the consumer's **Care Review** clinical formulation, **Care Plan**, and included in the **Longitudinal Summary** within CIMHA.

Question bank for violence

This question bank provides ***example questions*** to explore violence risk that will need to be tailored to the individual. **Note:** This is not an exhaustive list and is *not* intended to be used in a prescriptive manner or as a checklist.

General tips when starting a violence risk assessment interview

- Approach the interview process in a trauma informed and sensitive way.
- Explain the purpose of the interview, inform the person about confidentiality (including the limits to confidentiality) and gain informed consent to undertake the Violence Risk Assessment and Management (VRAM) tool assessment.
- Normalise the process as much as possible by letting people know that they are not the only ones asked these questions and who have this type of assessment.
- If at all possible, start with a discussion that is not related to violence or clinical pathology and allow the person space to share their story on their own terms.
- Start with broad, open ended questions and 'funnel' down into more targeted, violence related questions.
- You may need to meet with the person over several sessions.
- Questions should explore thoughts, feelings and behaviours associated with current and past violence. Explore with the person what was happening for them at the time (e.g. stressors, life changes) and what occurred after (e.g. how did they feel, any repercussions).
- Clarifying and summarising questions are a useful way to avoid misunderstandings.
- Use language the person uses/identifies with e.g. if they describe violence as 'getting aggro', use their words if their words are safe to use and do not contribute to self discrimination or self stigma.
- Try to differentiate between thoughts, feelings and behaviours.
- Try to capture a person's responses to critical information verbatim so you can use these quotes to illustrate your point when writing your VRAM.
- Remember to always check out the person's level of insight, judgement and capacity to make decisions (a current **Mental State Examination** (MSE) will need to accompany all violence risk screening and/or assessment).

Protective factors

- What do you enjoy doing? Do you have any hobbies?
- When you start to feel angry or upset, what do you notice (thoughts, feelings, behaviours). What do you think other people notice?
- When you want someone to talk to, or need some help, who do you reach out to?
- Are there things you do that help you not become violent? What are they?

General questions for physical violence and/or property damage

- When you've been upset or angry, how do you show that? Recall the worst argument you have had-tell me more about that?
- Have you every thrown objects? Damaged property? Punched or kicked property?
- Have you ever been hurt or injured in an argument? How did you respond to that?
- How close have you come to hurting someone? What happened?
- Have you ever hurt anyone? How come?
- What is the most physically aggressive thing you have ever done? Tell me more.
- Do you ever get into trouble at school? Suspended or excluded? What happened?
- Have the police ever been involved or attended for a fight/argument/conflict?
  - When was this? Why? Who else was involved?
  - What was going on for you at the time?
  - When else were the police involved?
- I noticed in your medical records that you were arrested in XXXX, can you tell me a little more about that?
- Timeline approach: I want to hear your story from the beginning. Tell me about the first fight you ever had.
  - Who was it with? Where? Why?
  - What was going on for you at the time?
  - When was your next fight?

Target victim(s)

- Do you feel you need to protect yourself at present? Against what/who? Why do you feel this way?
- Do you currently feel angry towards anybody or is there anybody you would like to 'teach a lesson' or 'get even' with? How come?
- Do you ever think about or picture hurting someone? Who? How come?
- How often do you have these thoughts?
- What do you think about or picture yourself doing?
- Do you think you will/have you ever acted on these thoughts?
- Do you think there's anyone who seems to be out to get you/hurt you or done you wrong? How are you protecting yourself from them? What would you do if you saw them?

Triggers for violence

- What or who triggers your anger and aggression? Why?
- Are there things trigger you more quickly or immediately? What are they?
- Are there things that you would say are more slowly triggering? So, they might be things that you spend a lot of time thinking around? Or things you get stuck on, or dwell on, in your mind?
- Tell me about the last time you felt really angry/you behaved aggressively? What was going on for you at the time?

Alcohol and drugs

- Have you ever been violent when using alcohol or drugs?
- What did you do?

Charges/legal orders

- Have you ever been in trouble with the police or had any charges?
- What were the outcomes e.g. diversion?
- Have you ever had a Domestic and Family Violence Order (DVO) against you?
- Have you gone to court because of violence?
- What were the outcomes/what happened when you went to court?

Weapons

May include everyday items (i.e. chair, kitchen knife) and legal/illegal weapons (i.e. crossbows, firearms, 3D printed guns, paintball guns, flick knives, martial arts equipment, bombs, explosives).

- Have you ever used an item or object, like a knife, tool, or gun, to hurt others or protect yourself?

Further prompts:

- What did you use?
- How did you access the [insert name of object/item]?
- When was this?
- What was the purpose?
- Who did you use the [item/weapon] on?
- Were they injured/were you injured? To what extent?
- Do you have access to a weapon/where is it now?
- Where do you store the weapon?
- Have you moved it closer recently (e.g. from the safe to the lounge room)?
- Do you keep the weapon loaded/ready to use?
- Have you ever wished you had access to a weapon like a gun when you were angry?
- Have you ever felt the need to carry a weapon for protection?

If there is an **immediate safety risk** or concern about a weapon, notify QPS by **calling 000** (Triple Zero). For less urgent matters, contact Policelink (131 444) or your local police station.

If health practitioners are of the opinion that a person is an unsuitable person to possess a firearm it is mandatory to make a QPS notification. For further information, including the

Notification to Weapons Licensing form, see: Mental and physical health | QPS https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health

Threats

- Have you ever made threats to harm someone? How? (e.g. verbally, social media)

Further prompts:

- Who was the threat directed to? When?
- What did you say/write (e.g. type of threat such as suicidal, homicidal, of physical violence, mass violence, of sexual violence, property damage or veiled threats?)
- Did you act on the threat?
- Have you made any plans to act? Or accessed any means?
- Do you still want to harm the person now?

Domestic and family violence

Introductory

- Who do you live with at the moment?
- How do you get along with the people you live with?
- How many long term relationships have you had in your life?
  - Can you tell me a bit more about why the last ones ended?
- Are you in a current serious/romantic relationship?
- How are things at home/with your partner?
- Most couples argue sometimes, how do you and your partner handle disagreements or conflicts?

More targeted

- Do you think your partner (or children) are ever scared of you?
- Have you ever said or done anything that you later regretted?
- Do you ever feel jealous when your partner is with other people?
- What do you think about your partner working/studying outside the home?
- What do you think about your partner spending time with their family/friends?
- Do you expect your partner to do what you want them to? Do you shout at your partner or treat them differently if they don't do what they are told?
- Have you ever pushed or hit your partner?
- Have you ever threatened to hurt your partner? With a weapon?
- Have you ever hurt your partner?
- Have the police every attended for an argument or fight?

If working with the **victims of DFV**, reach out to your local DFV coordinator Contacts and referrals | Queensland Health Intranet, and there are tools you can use to support the assessment as well:

- Domestic and family violence common risk and safety framework
- Domestic and family violence risk assessment tool - Level 2

Fire setting

- Have you ever intentionally set a fire, other than in a fireplace or firepit?

Further prompts:

- When? How come you set the fire?
- Had you been thinking about setting the fire for a long time beforehand?
- What did you use to start the fire?
- What was the outcome/did anyone get hurt/property loss?
- How many fires have you set in your life? Tell me about each one, let's start at the beginning.

Grievances

- Do you ever feel you have been treated unfairly?
- Do you feel that someone/a group/an organisation has done the wrong thing by you?
- Do you still feel that way about them now?
- Have you ever taken action to address being treated unfairly/wronged?
- What did you do? What would you do? What has stopped you?

High risk psychotic symptoms (associated with increased risk of violence)

Command hallucinations

- Sometimes when people are stressed, they hear things that others can't hear such as footsteps, music, noises or voices. Does this ever happen to you?

Further prompts:

- Can you tell me a bit more about what you experience?
  - Do they ever tell/command you to do things? (if present, explore both harm to self and harm to others)
  - What do they ask you to do?
  - Do you do follow their instructions?
  - How do these experiences make you feel? (e.g. distress, anger, fear).

Delusions

Sometimes people feel like others are watching them too closely or people might be trying to hurt them, harm them or make their lives difficult in some way. Has this been happening to you?
If yes, ask: Tell me a bit more about what you have noticed?

Delusional jealousy

- Is there anything in your current relationship that you find worrying/troubling/challenging?
- Do you ever worry that your partner might be unfaithful?

Delusional misidentification

- Have you noticed anything unusual or a little different that you can't quite explain about anyone close to you recently?
- Do you feel like anyone close to you or around you is/are imposters?
- Who?

Further prompts if yes

- On a scale of 1 – 10 (1 not convinced/10 totally convinced), how convinced are you that your partner is unfaithful or this person is an imposter?
- What makes you believe this might be the case?
- How often do you worry about/think about this?
- Is there anything that might change your mind?
- Have you had similar worries of unfaithfulness or imposters with other partners/people in the past?
- Have you ever tried to harm the person you think they were unfaithful with before?
- Have you ever tried to harm your partner before?

Note: Check in around the presence of any current or past controlling and/or monitoring behaviours, especially in relation to delusional jealousy.

Beliefs about a special purpose/mission

- Do you ever feel that you have a special role or mission that others don't have?

Further prompts:

- Tell me about the mission/special role (e.g. What is it? How long has it been going on? Who else is involved?)
- How do know this is your role? What tells you that?
- Might you need to harm someone in order fulfil your mission/role?

Sexual harm

- Have you had someone reject your sexual advances in the past? How did you feel? What did you do?
- How do you initiate having sex with someone?
- What does consent mean to you? What do you think this involves doing?
- Have you ever continued sexual activity after someone said no?
- Have you ever pressured someone into having sex?
- Have you ever been accused of or charged with a sexual offence? Towards whom? What happened? When?
- How do you feel about this now?

Sexual interest in children

- What age can people have sex? Or what is the age that you would say that a person would be too young to have sex?
- What do you think the dangers are of people under the age of consent becoming involved in sex?
- Have you ever thought about children in a sexual way?
- Have you ever viewed child pornography?
- Have you ever been sexually involved with children?

Stalking (repeated unwanted contacts)

- Have you ever tried to contact someone when they did not want to be contacted?

Further prompts:

- Who? How often were you contacting them? Why were you contacting them?
- How did you go about contacting them? (e.g. phone, social media, showing up to their home/workplace/places you knew they frequented)
- Why were you contacting them?

- Has anyone ever asked you to stop contacting them?

Further prompts:

- Who? Why? When?
- How did it make you feel when you were asked not to contact them?

- Have you ever thought about/pictured hurting/harming them?

Collateral gathering for violence

The purpose of this document is to support clinicians when gathering collateral from family, carers, Kin and significant personal supports (who may have been victims of violence) to gather information safely when assessing and responding to violence. Example questions are provided that will need to be tailored to the individual situation.

Please note, this is not an exhaustive list or intended to be used word-for-word or as a checklist.

Maximise engagement and minimise harms

- **Use a trauma informed approach:** Check in, offer choice, ensure people know the process is voluntary and they can withdraw at any point.
- Where relevant, utilise interpreters who speak the person's first language. Where possible involve a cultural consultant (Multicultural Mental Health Coordinators | Queensland Health) or (with consent) an indigenous worker.
- Explain that gathering detailed information assists the team with understanding the types of violence, frequency and patterns of behaviour as well as guide response planning.
- Explain the information is documented in the electronic clinical record and may be requested by the person being discussed. Check if the person providing collateral has any safety concerns due to this and if so, ensure you add a *Release of Information* alert and caveats in the relevant clinical notes to flag not to disclose the third-party information as it may increase risk to the person providing the collateral.
- Discuss with multidisciplinary team (MDT) if you are unsure about any of this.
- Be prepared to give the person information on support services that are relevant and available to them if they require support, have been victims or are at risk of future victimisation.
- Not all people who provide collateral will have been victims; where they have been it will be important to work in trauma informed ways and to offer support as indicated.

What to cover

When gathering collateral, you will potentially need to cover the following:

- if indicated, provide basic **victim support,** linkage and referral to the person providing collateral
- gather, clarify and/or confirm information about the person having the VRAM tool, including their:
  - **background/broader history** where there are gaps or inconsistencies e.g. childhood, family, pre-morbid functioning, psychiatric, alcohol and other drugs (AOD), general offending and/or antisocial behaviours in the past.
  - **violence history:** types of violence, victims, warning signs, triggers, context, perpetuating/maintaining factors and protective factors, as well as what helps to prevent/manage violence.

There are question banks below to assist with gathering collateral around violence.

Victim support

Many people we gather collateral from are victims or are at ongoing risk of victimisation. They may have support needs, require some basic safety planning advice, referral and/or linkage to specialist support.

Consider if it would be helpful/relevant to the person providing collateral to explore any of the following:

- What does or would make them feel safe?
- How do they protect themselves at times of increased risk?
- What safety plans do they have?
- Do they know who to call if there are imminent safety concerns regarding the person? Do they have a plan for calling 000 if they have imminent risk concerns?
- Who do they contact if there are less urgent safety concerns regarding the person?
- Ensure that they have all relevant contact details for the mental health service including 1300 MH CALL/Treating Team.
- Encourage proactive information sharing with the treating team about early warning signs (EWS), symptoms, concerns and risks.
- Do they have social supports to talk to about the impact of the person's mental illness and/or violence?
- If not consider the need for linking with services such as Arafmi (support for mental health carers), Children of Parents with a Mental Illness (COPMI), Carers Queensland mental health counselling, AfterCare, IPRA (Independent Patient Rights Advisers), Carer Peer/Senior Carer Coordinator, General Practitioner (GP) for mental health care plan (MHCP).
- Would it be helpful to make a referral to a Queensland Health domestic and family violence (DFV) clinician or High Risk Team (HRT) for further safety planning and support? Contacts and referrals | Queensland Health Intranet.
- Or to liaise/link with other victim support services with consent (e.g. Domestic Violence Action Centre, Domestic and family violence help in Queensland, Home | 1800RESPECT, Queensland Health Victim Support Service | Queensland Health).
- Discuss with the MDT if you are unsure of how to respond.

Physical violence

Is there a history of **physical violence**? *If yes*:

- Age of onset? (be sure to check for violence that occurred as a child (12 years and younger), as an adolescent (13 to 17 years) and as an adult)
- What occurred, when, against who and the consequences (i.e. school exclusion, court, sentence, police charges)?
- What was the most serious violence?
- Is there ongoing contact with victims? Is there ongoing victimisation or risks? If yes:
  - consider ethical issues, information sharing and relevant legislation (Information sharing | Queensland Health)
  - consider the need to refer to relevant services (outlined above).
- What does the person providing the collateral think influenced or caused the violence (i.e. symptoms, intoxication, mood)?
- Are there any patterns? Does it get worse when the person has been using alcohol or drugs?
- Has the person used weapons in the past?
- Have there ever been times when you thought your life was in danger?

Verbal threats of harm

Is there a history of **verbal threats**? *If yes*:

- How long has the person being making threats?
- What type of threats (i.e. suicidal, homicidal, physical violence, mass violence, sexual violence, property damage or veiled threats)?
- What occurs during these threats (e.g. they threaten to kill their neighbour while holding a knife and posturing)?
- Who are the targets?
- Is there ongoing contact with victims? Are there ongoing victimisation or risks?

  If yes:
  - consider ethical issues, duty to warn/protect and relevant legislation (Information sharing | Queensland Health)
  - consider the need to refer to relevant services (outlined above).
- Have threats been followed by actual violence/harm/damage to property?
- What influences/drives threats or demanding behaviours (i.e. specific symptoms, intoxication)?
- Do they identify any patterns?

Weapons

May include everyday items (i.e. chair, kitchen knife) and/or legal/illegal weapons (i.e. crossbows, firearms, 3D printed guns, paintball guns, flick knives, martial arts equipment, bombs, explosives).

- Is there a history of using items in the environment as weapons?
- Is there any history accessing illegal weapons?
- Is there a history of carrying weapons with them?

If yes to any/all questions, probe further:

- What type of weapons?
- How did the person access them?
- When did they access them?
- What was the purpose?
- Does the person have access now?
- Where does the person store them?
- Can they access weapons (e.g. firearms) illegally if they wish to?

If there is access to a firearm, refer to health practitioner notification requirements for Queensland Police Service (QPS): https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health.

Sexual violence

Is there are history of **sexual violence**? *If yes*:

- What occurred (gently prompt if required, e.g. rape, attempted rape, touching, exposure, observing others without their awareness, rubbing up against others, sexually inappropriate remarks, threats of sexual harm to others and so on)?
- When did this start? What has occurred and when has this occurred? How often? Against who (i.e. age, gender)? Where has it occurred? What were the consequences?
- Does the person ever make sexualised, derogatory or degrading comments of a sexual nature?
- Is there ongoing contact with victims? Are there ongoing victimisation or risks? If yes:
  - consider ethical issues, duty to warn/protect and relevant legislation*
  - consider the need to refer to relevant services (i.e. VSS or DVConnect)
- What do they think influenced or caused the behaviour?
- Do they identify any patterns?
- Are there any sexual behaviours that others do not know about and they have not gotten into trouble for?

If the person you're gathering collateral from is a partner/spouse:

- What happens when you say no to sex? How do they respond? (e.g. what do they say, how do they behave?)

Is there ongoing contact with victims? Is there ongoing victimisation or risks?

If yes:

- consider ethical issues, duty to warn/protect and relevant legislation (Information sharing | Queensland Health)
- consider the need to refer to relevant services (outlined above).

Ensure mandatory notification of harm to a child/children occurs as per your local HHS procedure.

Stalking (repeated unwanted contacts)

Is there any history of **stalking type behaviour**? *If yes*:

- What sort of behaviours (prompt if necessary: making phone calls, visits to the victim, approaching the victim, sending letters/texts/emails, recording the victim)?
- When did this start/finish?
- Against who? Details of the victims (i.e. gender and age)?
- What is the relationship between the victim(s) and the person?
- How many victims?
- Have the victim(s) or anyone else asked the person to cease contacting them?
- Does the person know the victim's address, workplace or other ways to contact the victim(s) at present?
- Has the person threatened the victim(s) – what have they said or done?
- Have the police become involved as a result of this behaviour?
- Is there ongoing contact with victim(s)? Is there ongoing victimisation or risks? *If yes*:
  - consider ethical issues, duty to warn/protect and relevant legislation
  - consider the need to refer to relevant services (i.e., DFV Coordinators or DVConnect).

- What do they see as driving the behaviour (i.e. preoccupation with a potential love interest or believe the person is in love with them, fixated on a cause or a grievance, a grudge, seeking revenge, seeking justice and so on)? It will be useful to formulate specific questions on the hypothesis you have of what is driving the behaviour prior to seeking collateral.
- How much of the person's time is spent on talking about their victim and/or engaging in the particular behaviours?
- Is there ongoing contact with victims? Is there ongoing victimisation or risks?
  If yes:
  - consider ethical issues, duty to warn/protect and relevant legislation (Information sharing | Queensland Health)
  - consider the need to refer to relevant services (outlined above).

Forensic history and antisocial behaviour not captured above

- Has the person ever been in trouble with the police, gone to court or to prison?
- Has the person ever expressed or held beliefs or strong opinions about authority figures such as the police or the government? *If yes*:
  - Do they tend to show/express a distrust for authority figures? (i.e. who specifically?)
  - What do they say/do?
  - Have you seen them interact with authority figures? What happened?
- During childhood or adolescence has the person ever engaged in antisocial behaviours?
- As an adult has the person ever engaged in antisocial behaviours?
- Have there been any property damage, disputes, fraud, gang involvement, drug manufacturing/trafficking or other concerning behaviours or worries you have that we haven't discussed?
- Do you know of any other behaviours or problems with the law in other states or countries?
- Is there anything else that we haven't talked about that you would like me to know/think is important for us to know?

Current/Future catch all questions

- What **current concerns** do you (the person providing collateral) have about risk?
- What about in the **future**, what could happen do you think?

*****Revisit victim support at the end of gathering collateral.**

Please see the guide around this in the earlier section***

Adult strategies for managing violence

Here are a range of different strategies for adults* that may be useful to consider when creating an individualised plan to manage violence risk.
The following management strategies are covered. ***For child and youth strategies, refer to the dedicated resource.**

Violence risk increasing factors: Example risk management strategies	Protective factors: Example risk management strategies
• Overarching violence risk management strategies • Unclear clinical formulation/diagnostic picture • Active symptoms associated with violence • Substance use • Trauma reactions and emotional dysregulation • Access to potential victims • Access to weapons/firearms • Problems with living situation or homelessness • Poor insight into violence risks • Problems with engagement or adherence with treatment • Violent ideation • Stress and coping deficits • Attitudes supportive of violence • Intellectual disability • Dementia • Relationships or social interaction or communication skills • Lack of purposeful/meaningful activity • Rural and remote • Unknown /incomplete data.	• Engaged with the service • Personal supports engaged • Employment/positive activities • Aboriginal and Torres Strait Islander Peoples: Connection to culture, social and emotional wellbeing.

To use these in practice, you may select relevant strategies for the person depending on the risk and protective factors identified during the VRAM tool.

Please ensure that the VRAM tool risk management plan is:

- individually tailored based on the person's unique VRAM tool formulation and their particular risk increasing factors
- discussed with relevant personal supports and external stakeholders
- lists who is responsible for each strategy and when each will be reviewed
- embedded in the Care Plan by the Principal Service Provider (PSP).

Violence risk increasing factors: Example violence risk management strategies

Overarching violence risk management strategies

Practice approaches

- Adopt a trauma informed, person centred, culturally sensitive and compassionate engagement approach with the person and their supports/significant others.
- Consider diversity:
  - tailor strategies to meet the individual needs (e.g. adaptations for intellectual impairment, language, neurodiversity)
  - involve relevant professionals and services in all stages of assessment and response (with consent and where appropriate) e.g. Health Workers, Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ATSICCHOs), Queensland Transcultural Mental Health Service (QTCMHS) cultural consults, gender services
  - utilise interpreters who speak the person's first language and where possible engage a cultural consultant (Multicultural Mental Health Coordinators | Queensland Health).
- Maintain/build protective factors and strengths.
- Involve lived experience workers in care.
- Provide a consistent PSP and assertive long term case management.

Operational considerations

- Specify the frequency of future risk screening or repeat VRAM tools, increasing this during periods of higher risk or foreseeable changes, adapting the management plan as required.
- Step up/down care: based on need (e.g. periods of higher need require more frequent contact and case follow up).
- Consider the need to increase the ratio of staff (e.g. two person home visits).
- Maintain alerts on all relevant databases (i.e. CIMHA, The Viewer, ieMR). Alert examples could include access to weapons, Domestic and Family Violence (DFV) (e.g. details of Domestic Violence Orders), aggressive behaviour. Alerts do not always automatically flow into other systems and databases, so there may need to be some dual entry.
- Increase communication with other staff and relevant stakeholders i.e. Non government organisations (NGOs) around concerns and monitoring of risks (e.g. daily debriefs on ward).
- Utilise the Assessment and Risk Management Committee (ARMC).
- Consider involving the Forensic Liaison Officer (FLO).
- Consult/involve the **DFV Specialist Health Workforce** if indicated: Contacts and referrals | Queensland Health Intranet.
- Conduct regular meetings between all relevant stakeholders to share timely information around the risk profile and agreed response plans.
- Consider the need for a(n):
  - Police Advice and Intervention Plan (PAIP)
  - Acute Management Plan (AMP)
  - Involuntary Patient and Voluntary High Risk Patient Summary.
- Consultation with Community Forensic Outreach Service (CFOS Tier 3 – discuss with FLO prior).

Unclear clinical formulation/diagnostic picture

- Undertake a comprehensive diagnostic assessment, formulation and care planning process.
- Consider the need for an admission to contain the risks until the diagnoses, care plan and treatment (where indicated) is commenced.
- Ensure clear delineation and understanding of triggers, drivers, and maintaining factors for violent behaviour.

Active symptoms of mental illness associated with violence

- Assertively treat symptoms.
- When the person is ready, willing and able provide psychoeducation around the links between psychosis and violence as well as skills training to the person and significant others (e.g. family) in recognising and managing symptoms.
- Consider therapeutic intervention and relevant skills training groups – e.g. Cognitive Behaviour Therapy (CBT) for psychosis.
- Monitor for the presence, frequency, duration, intensity, severity or increase of symptoms.
- If meets criteria, place on Early Psychosis Care Pathway | Mental Health, Alcohol and Other Drugs Branch.
- Consider the need to have a low threshold for an admission to hospital.
- Review medication.

Substance use

- Use motivational interviewing, harm reduction and trauma informed approaches.
- Follow the Co-occurring substance use disorders and other mental health disorders policy.
- Provide psychoeducation around the links between substance use and violence and if indicated brief interventions when the person is ready, willing and able: Insight - Toolkits - Insight's Check Tools.
  - based on individual need and depending on what the function of the substance use is, consider trauma therapy, sensory approaches, Narrative therapy or CBT
  - consider monitoring via self report and/or urine drug screens (UDS)
  - consider consultation with or referral to local Alcohol and Other Drugs (AODS) team for further assessment and intervention.

Trauma reactions and emotional dysregulation e.g. anger, impulsivity

Work with the person and their significant others to:

- establish a trauma informed therapeutic alliance
- provide psychoeducation around the links between trauma and behaviours e.g. sexual violence, fire setting, physical violence, threats, aggression
- utilise culturally based intervention frameworks if relevant and identify and address cultural needs i.e. Sorry Business/Sad News, interrupted/unresolved grief, trans and intergenerational trauma
- collaboratively identify and practice strategies (e.g. sensory approaches) for managing stressors, triggers (e.g. situations, places or people) and/or trauma responses across a range of environments (consider cultural frameworks if relevant)
- keep key documents such as Acute Management Plans (AMPs) updated
  - with consent, communicate the AMP with key stakeholders.
- refer to relevant therapeutic groups if available.

Access to potential victims

- Information should be shared with consent wherever safe, possible and practical and with consideration to how the process of obtaining consent may unintendedly increase risk to potential victims e.g. DFV situations. When determining the need to breach confidentiality due to violence risk, the multidisciplinary team (MDT) will need to:
  - carefully consider the **Information sharing in mental health alcohol and other drugs care: Guidance on sharing information** available here: Information sharing | Queensland Health and gather legal advice where possible as every scenario is different
  - in some HHSs the FLO/Mental Health Intervention Coordinator (MHIC) may also be able to assist with these discussions.
- Consider the need for an admission to contain risk and treat the underlying drivers (e.g. if a person has incorporated someone into persecutory delusions).
- Consult with the treating consultant psychiatrist around changes to Limited Community Treatment (LCT) conditions regarding accommodation or location.
- Increase monitoring of the risks via regular reviews and obtaining ongoing collateral around the person's early warning signs (EWS), triggers, stress/coping and foreseeable changes.
- Develop a detailed **victim safety plan** with identified targets for future harm (e.g. early intervention, setting boundaries safely, calling the police if required).
- If safe, recruit a third party who is not a potential target to monitor the person and limit their access to potential victims.
- Contact the Child Protection Liaison Officer (CPLO) if you have welfare concerns regarding a young person or mandatory reporting is required.
- Seek advice from the DFV coordinator for the Hospital and Health Service (HHS) Contacts and referrals | Queensland Health Intranet.
- Consider a referral to the DFV High Risk Team (HRT).
- Liaise/link with the victim support services with consent (e.g. Domestic Violence Action Centre, Domestic and family violence help in Queensland, Home | 1800RESPECT, Queensland Health Victim Support Service | Queensland Health).
- Provide ongoing psychoeducation and relapse prevention/planning with the person around their Early Warning Signs (EWS) and triggers, high risk scenarios and foreseeable changes that could lead to violence.
- Where **staff** are identified as potential targets consider the guidance around Occupational Violence (Occupational violence and aggression | Queensland Health Intranet) to develop a risk management plan. You may need to consult with Tier 3 services when there are more complex types of risk i.e. stalking a staff member.

Access to weapons/firearms

This may include everyday items e.g. chairs, kitchen knives; and legal/illegal items e.g. firearms, crossbows, 3D printed guns, paintball guns, martial arts equipment, explosives, bombs.

Access to weapons/firearms – general information.

For immediate or urgent safety concerns about someone's behaviour or access to a weapon, call Triple Zero (000). For non urgent matters, contact Policelink (131 444) or your local police station.

General considerations:

- continue to consider the person's ongoing access to weapons as part of the routine risk screening process
- assist the person to develop insight into the potential risks of having access to weapons
- assist the person to address emotional regulation, decision making and attitudes or other factors that influenced them to access weapons with person centred/relevant psychosocial interventions i.e. CBT, sensory approaches and consider developing a violence safety plan
- consider asking the person to remove or reduce access to everyday items used as weapons if feasible and safe to do so.

Access to firearms – this may include legal or illegal firearms, such as 3D printed guns.

Firearms notifications to Queensland Police Service (QPS)

A health practitioner, classified as a 'professional carer' under the *Weapons Act 1990*, may notify QPS if they are of the opinion that a person is unsuitable to possess a firearm due to a mental or physical condition; or the risk of being a danger to themselves or others.

'Professional carers' are defined as doctors, nurses, psychologists, social workers and professional counsellors. If a health practitioner is from another profession (such as a midwife or occupational therapist) and is of the opinion that a disclosure about a person's suitability to possess a firearm should be made, they should escalate these concerns to a clinician who is a professional carer or the person's broader multidisciplinary care team.

If a person has access to a firearm, refer to the 'Firearms notifications by health practitioners' for information about notification to QPS using the Weapons Notification Form. The information booklet and Weapons Notification Form are both available here: https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health

Health practitioners working for a Hospital and Health Service must notify QPS if they are of the opinion that a person is unsuitable to possess a firearm, using the following steps:

1. complete the Notification to Weapons Licensing form found here: https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health
2. email the completed Weapons Notification Form to QPS and save a copy of the completed notification to the person's relevant clinical records (e.g. CIMHA, ieMR, The Viewer)
3. review/update alerts on all relevant clinical records (e.g. CIMHA, ieMR, The Viewer)
4. although not a routine requirement, consider the need to contact QPS to discuss a collaborative stakeholder plan/establish when they will be able to remove weapons and/or if they can confirm this has occurred e.g. before the person is discharged.

Access to weapons (other than firearms) – this may include everyday items e.g. chairs, kitchen knives; and legal/illegal items e.g. crossbows, paintball guns, martial arts equipment, explosives, bombs.

If a health practitioner is concerned that a person has access to a weapon (other than a firearm), disclosure can be made to QPS under section 147 of the *Hospital and Health Boards Act 2011* to assist in lessening or preventing a serious risk to life, health or safety, or public safety.

The need for the disclosure must be on reasonable grounds, the risk must be serious and the disclosure must be necessary to assist in lessening or preventing the risk The health practitioner also needs written approval from their relevant chief executive, although this power may have been delegated to a local level.

Problems with living situation or homelessness

- Involve supportive people (family/Kin, friends) to identify alternative accommodation options.
- Assist with referrals to secure alternative accommodation and consider involving a relevant NGO for support.
- Liaise with accommodation providers about concerns.
- Work with DFV High Risk Team, Department of Housing, NGOs or other relevant agencies in the HHS if the person is at risk of homelessness or requires more suitable housing due to overcrowding.
- Ongoing supportive counselling/problem solving around the issues in the home environment e.g. psychoeducation around conflict management.
- Provide information for relevant support services to family/carers (e.g. Arafmi, Wellways (support services for mental health carers), Mental Health Care Plan (MHCP).

Poor insight into violence risks

- Using the findings from the VRAM tool, undertake a shared collaborative formulation with the person and significant others to assist them to identify or better understand their unique early warning signs, triggers, what maintains behaviours, high risk situations and foreseeable changes and from there plan adaptive coping responses.
- Where relevant/possible treat aspects of illness impacting insight (e.g. consider medication for depression impacting cognition).

Problems with engagement or adherence with treatment

- Re-assess/identify the reasons and attempt to address the identified needs.
- Provide psychoeducation about the reasons for Mental Health Alcohol and Other Drugs Services (MHAODS) involvement and ways biopsychosocial interventions can help.
- Work to establish a positive rapport and solid therapeutic relationship.
- Involve the person and their personal supports in their care planning, recovery and risk management planning.
- Work to eliminate any dynamics in which the mental health service is associated with perceived punishment or shame.
- Maintain a consistent approach within and between the treating team(s).
- Consider the impact of possible transference and/or countertransference on the person's desire to engage with mental health services.
- Investigate and address side effects of medication:
  - support physical health by linking with metabolic monitoring clinic and/or provide regular metabolic monitoring.

- Consider the need for admission.
- Consider the need for provisions under the Mental Health Act 2016.
- Offer choice and consider where possible preferences around modes of medication administration (e.g. oral vs depot).
- Consider administration of depot.
- Monitor serum levels, if available.
- If decision making capacity for medication/treatment is of concern, consider if substitute decision makers are required according to the Less Restrictive Way Guidelines.

Violent ideation

- Undertake psychoeducation e.g. a chain analysis of violent behaviour to better understand precursors to violence.
- Consider if CBT or other evidence based interventions are indicated.
- Collaboratively develop a relapse prevention plan in relation to violence to build on non violent coping strategies.
- Monitor via serial mental state examinations and risk screen reviews.
- Address underlying drivers e.g. work on trauma, treat symptoms of depression or psychosis.
- Create victim safety plans with individuals identified at risk. Consult/involve the **DFV Specialist Health Workforce** if indicated: Contacts and referrals | Queensland Health Intranet.

Stress and coping deficits

- Use a motivational interviewing and person centred approach, positioning the person as an expert in their own lives, with agency and autonomy.
- Regularly engage in open conversations to collaboratively explore problems, stressors or foreseeable changes and support and guide the person with identifying adaptive ways to manage these as they arise.
- Affirm adaptive internal and external coping strategies.
- Assist the person to proactively monitor their stressors, coping response/strategies and to look for additional/alternative social supports if they are to break down.
- Expand the person's repertoire of strategies by introducing relevant/suitable self directed strategies (e.g. sensory approaches, deep breathing, using apps, help seeking).

Attitudes supportive of violence

- Consider using motivational interviewing to prepare the person to engage in further work (depending on their stage of change).
- Consider, for example, CBT and compassion focused therapy to foster victim empathy/perspective taking, cost/benefit analyses including discussing personal consequences of violence (e.g. legal, time, mental health, education, relationship impacts), target emerging core beliefs and identify strategies to manage self talk around violence.
- Assist in engaging in active problem solving and decision making exercises to identify alternate strategies.

Intellectual disability

- If relevant confirm a National Disability Insurance Service (NDIS) support package is in place and meeting the level of need or if re-referral is required if the package is insufficient for the level of need. If not already in place, consider if a NDIS referral is indicated.
- Consider if substitute decision makers are in place or are required and who may be best placed to do this. Consider if an application to Queensland Civil and Administrative Tribunal (QCAT) is required to appoint substitute decision makers if family, Kin, friends or carers are unavailable or unsuitable.
- Undertake an ARMC meeting or liaise with Tier 3 services.
- Consider making a referral to the local HHS Mental Health Intellectual and Developmental Disability service or liaising with the Queensland Centre of Excellence in Intellectual Disability and Autism Health - Mater.
- Follow the Positive Behaviour Support Plan (PBSP) if available or if indicated request for one to be developed.
- Identify individual communication needs/approaches e.g. communicate in the ways outlined in the PBSP.
- Adapt and tailor interventions based on developmental stage and the cognitive functioning of the person (e.g. communication ability, information processing, attention or memory problems).
- Work closely with family, carers, NDIS, NGO care staff, or other relevant stakeholders.
- Consider the environmental factors e.g. triggers for sensory overload.
- Consider ratio of staff e.g. 2:1 minimum.
- Ensure staff and stakeholders are aware of EWS, triggers and responses to de-escalation and proactively ensure there is a plan for implementation of safety measures by staff.
- Communicate in a calm and considered manner, using short simple sentences, language they understand and avoid arguing or confronting the person.
- Identify high risk scenarios, communicate with staff around these and have an escalation plan in place.
- If staff are potential targets:
  - consider inter positioning by placing a barrier/furniture e.g. a table between the worker and person if they start to escalate
  - work with staff to have an exit plan ready e.g. all exit points identified each shift, have car keys/phone handy, in clinical spaces arrange for security to be onsite
  - identify ahead of time what the threshold is for calling triple zero (000).
- Establish daily debriefs/handovers with staff and consider if written logs are needed to capture patterns of behaviour including EWS, triggers and so on.
- Have clear communication pathways between providers and the PSP/treating team.
- Identify relevant training that is available and accessible for care providers or family.
- Consider an AMP and/or PAIP.
- Consider completing a Julian's Key Health Passport | Queensland Health if relevant.
- Ensure regular physical and dental health checks (as medical conditions can escalate behaviours and the person may not be able to communicate this).

Dementia

- Consider the most appropriate placement while balancing autonomy/least restrictive care e.g. placement at a dementia informed environmentally designed Residential Aged Care Facility (RACF), use of high dependency/secure areas in a flexible /time limited way is possible.
- If not already in place, refer to My Aged Care for an assessment. Referral to a geriatrician or memory clinic may also be indicated if cognitive impairment has not yet been formally diagnosed.
- Consider referral to specialist dementia services available in the HHS (Dementia RACF support services | Queensland Health) for advice around management of behavioural and psychological symptoms of dementia (BPSD), such as agitation, anxiety, depression, disinhibited behaviours. Sometimes a behaviour management plan may be developed, complimenting a VRAM tool.
- Monitor closely for physical deterioration and assertively manage/treat (e.g. delirium). Ensure staff access training around this on iLearn if needed.
- When indicated, undertake daily behavioural monitoring, avoid escalation and utilise de-escalation approaches assertively (Roberton & Daffern, 2022).
    1. Identify and address situational triggers, including:
        - unmet needs e.g. agitation, pain, discomfort, hunger, tiredness, dehydration, or confusion
        - interpersonal interactions e.g. communicate in a calm and considered manner, use short simple sentences and avoid arguing or confronting the person
        - the physical environment e.g. reduce access to victims, means, noise, overstimulation, bright lights, maintain predictable daily routines and staff where possible.
    2. Provide immediate therapeutic intervention, including:
        - activities
        - sensory interventions
        - physical arousal reduction
        - social contact
        - consider medication.
- Provide support and training for (paid and unpaid) carers and staff around the above and in monitoring early warning signs (including physical signs e.g. urine screening for infections that may lead to delirium), triggers and responding to escalation without relying on physical or chemical restraints.
- Encourage carers to keep records of triggers, behaviours and what works to de-escalate the person.
- Ensure there are handovers and regular communication practices across all professionals involved in care e.g. visiting medical officers, nursing, allied health, paid/unpaid carers.
- Ensure potential targets:
    - consider inter positioning by placing a barrier/furniture e.g. a table between the worker and person if they start to escalate
    - work with carers to have an exit plan ready e.g. all exit points identified in the environment, have car keys/phone handy, in clinical settings arrange for additional staff to be present
    - identify ahead of time what the threshold is for calling triple zero (000).
- Consider the need for an AMP and/or a PAIP.

Relationships or social interaction or communication skills

- Link with social skills groups (if available).
- Link with local DFV group therapy (if available).
- Provide interventions targeting communication skills and social problem solving.
- Develop confidence via rehearsing/roleplays in sessions.

Lack of purposeful/meaningful activity

- Link with NGOs, volunteer groups, community activities or other relevant support groups.
- Provide supportive counselling, goal setting/planning, problem solving and/or brief interventions.
- Consider occupational therapy assessment to explore engagement in meaningful and purposeful daily activity, habit and routine formation.

Rural and remote

- If using telehealth, or if face-to-face reviews are few, consider the need to gather collateral from others more frequently e.g. have more communication with family/significant others to aid risk screening of deterioration in mental state and changes to dynamic risk factors.
- There may be a need to include regular communication or care by a Primary Health Clinic or if relevant ATSICCHOs.
- The PAIP needs to be contextualised to support QPS attendance delays if they are not co-located (e.g. QPS may be based over 100kms away).

Unknown/incomplete data

- PSP to transfer the VRAM tool risk management plan into Care Plan.
- Maintain detailed contemporaneous notes of all risk related information in CIMHA.
- Maintain CIMHA alerts.
- Gather more collateral from relevant personal supports and update formulation and management plan accordingly.
- Gather more collateral from relevant professional supports (e.g. General Practitioner (GP), ATSICCHOs, NGOs, NDIS).
- Gather QPS/Court history from the relevant Youth Justice Services or the Queensland Police Service. MHIC may also be able to assist in liaising with QPS.

Protective factors: Example management strategies

Engaged with the service

- Continue to adopt a trauma informed, person centred and compassionate based engagement approach with the person and their personal supports.
- Proactively monitor/identify risks and needs to respond assertively to changes where possible.
- Use a motivational interviewing approach when there are dips in engagement.
- Provide positive reinforcement, affirmations and feedback to the person and their personal supports around progress they have made/benefits of engagement.
- Continue to involve the person/significant others in their care planning, recovery and risk management planning.
- Work to eliminate any approaches by the mental health service that could create future barriers to engagement.
- Communicate early and often around any changes that are happening and assertively plan for staff absence or changes in case manager where foreseeable e.g. Case Manager who has good alliance going on annual leave.
- Have a process in place for clear communication/handovers between staff.
- Maintain a consistent approach within and between the treating team(s).
- Celebrate ‘wins’ and achievements together, no matter how small they may seem.

Personal supports engaged

- Maintain support from family/personal supports where possible by involving them (with consent) in the treatment/care of the person.
- Regularly follow up personal supports to check in, identify support needs and respond accordingly.
- Support family/significant others with their mental health, carer stress and link with services to avoid burnout e.g. Arafmi, Children of Parents with a Mental Illness (COPMI), Emerging Minds, Carer Gateway, GP for a MHCP.
- Ensure they know who and how to contact the MHAODS with concerns or requests.

Employment and/or positive activities

- Support the person to maintain employment during case management sessions and offer flexible appoints that fit around work.
- Maintain/encourage active participation in positive activities (e.g. sports, clubs, hobbies) during case management, by using a mentor, linking with relevant groups in the area of interest.
- Explore the possibility of expanding current activities (e.g. engaging in part time work, volunteering, TAFE, Open Universities, community activities)
- Identify financially sustainable options (e.g. discounted memberships or free access to local council activities or groups).

Aboriginal and Torres Strait Islander Peoples: connection to culture, social and emotional wellbeing

It is important to recognise that Aboriginal and Torres Strait Islander peoples' connection to culture is unique to each individual. Taking time to explore and understand what culture means to each person, and letting it guide an individual's care, is fundamental to supporting their mental health and Social and Emotional Wellbeing (SEWB).

The following considerations may be relevant and will need to be collaboratively explored with the person.

- From the point of referral for the VRAM tool ensure an integrated approach occurs by considering both the clinical and cultural needs of the person.
- With consent and where available, include Aboriginal and Torres Islander Health Workers, Practitioners, and/or Hospital Liaison Officers in the person's care.
- Support connection to family and Kin through psychoeducation, yarning, and ensuring Carer/Kin support needs are considered and met where relevant e.g. linking them with an ATSICCHO, and/or other local services.
- Support the person to engage in cultural practices e.g. traditional art/craft, music, dance, yarning and storytelling, hunting and fishing, community groups, land councils, cultural programs.
- Assist the person to carry out cultural roles and responsibilities, including minimising the impact of treatment and care where possible (e.g. offering flexibility around leave and appointments, particularly during times of Sorry Business/Sad News, ceremony, or other cultural obligations).
- Support connection to community events and celebrations (e.g. National Aboriginal and Islanders Day Observance Committee (NAIDOC), National Reconciliation Week (NRW), Coming of the Light)
- With consent, respectfully engage community Elders to support the person's recovery and cultural needs.
- Facilitate connection to land and Country and support the person to maintain this connection during absences e.g. facilitate access to natural environments or exploring whether meaningful objects from Country can accompany the person during inpatient care.
- Support the persons connection to spirit, spirituality, and ancestors e.g. providing space and opportunity for smoking ceremonies, supporting the use of traditional healing practices or the use of traditional medicines where safe and appropriate.
- Ensure care plans are holistic and consider co-occurring physical health needs, recognising that physical, emotional, spiritual, and cultural wellbeing are interconnected and integral to recovery.

Reference

Roberton, T. & Daffern, M. (2022). A protocol for responding to aggression risk in residential aged care facilities. *Australian Journal of Advanced Nursing, 39*(4). https://doi.org/10.37464/2020.394.631

Child and youth strategies for managing violence

Here are a range of different strategies for children and young people* that may be useful to consider when creating an individualised plan to manage violence risk. The following management strategies are covered. ***For adult strategies, refer to the dedicated resource.**

Violence risk increasing factors: Example risk management strategies	Protective factors: Example risk management strategies
• Overarching violence risk management strategies • Trauma reactions and challenges with emotional regulation • Unclear clinical formulation/diagnostic picture • Access to potential victims • Access to weapons • Problems with living situation or homelessness • Substance use • Poor insight into violence risks • Problems with engagement or adherence with treatment • Lack of connection with education • Parental/carer disengagement • Violent ideation • Attitudes supportive of violence • Negative social influences • Intellectual disability • Social interaction/communication skills • Active symptoms associated with violence • Rural and remote • Unknown /incomplete data.	• Engaged with the service • Family/carers engaged • Positive relationships with peers, mentors or other community members • Aboriginal and Torres Strait Islander Young Peoples: Connection to culture, social and emotional wellbeing • Stress and coping deficits • Commitment to school /education • Engages in positive activities.

To use these in practice, you may select relevant strategies for the young person depending on the risk and protective factors identified during the VRAM tool.

Please ensure that the VRAM tool risk management plan is:

- individually tailored based on the young person's unique VRAM tool formulation and their particular risk increasing factors
- discussed with the person/their family or carers
- lists who is responsible for each strategy and when each will be reviewed
- embedded in the Care Plan by the Principal Service Provider (PSP).

Violence risk increasing factors: Example violence risk management strategies

Overarching violence risk management strategies

Practice approaches

- Adopt a trauma informed, person centred, culturally sensitive and compassionate based engagement approach with the young person, their family/carer and any other key supports/systems.
- Adopt a systems approach by conducting regular meetings between all relevant stakeholders e.g. school, child safety, non government organisations (NGOs), Youth Justice, Cultural Consultants, Health Workers, Primary Health Clinics, Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ATSICCHOs) to identify and discuss early warning signs (EWS), triggers, foreseeable changes and agreed management strategies during periods of high risk/foreseeable changes.
- Tailor any strategies at a developmentally appropriate level for the young person.
- Consider diversity:
  - tailor strategies to meet the individual needs (e.g. adaptations for intellectual impairment, neurodiversity, cultural considerations)
  - involve relevant professionals and services in all stages of assessment and response (with consent) e.g. Health Workers, ATSICCHOs, Queensland Transcultural Mental Health Service (QTCMHS) cultural consults, gender services
  - utilise interpreters who speak the person's first language and where possible engage a cultural consultant (Multicultural Mental Health Coordinators | Queensland Health).
- Maintain/increase protective factors and strengths.
- Involve lived experience workers in care.
- Provide a consistent PSP and assertive long term case management.

Practice approaches

- Specify the frequency of future risk screening or repeat VRAM tools, increasing this during periods of higher risk or foreseeable changes and adapting the management plan accordingly.
- Step up/down care: based on need (e.g. periods of higher need require more frequent contact).
- Consider staff safety (e.g. two person home visits).
- Maintain alerts on all relevant databases (i.e. CIMHA, The Viewer, ieMR). Alert examples could include access to weapons, Domestic and Family Violence (DFV) (e.g. details of Domestic Violence Orders), aggressive behaviour. Alerts do not always automatically flow into other systems and databases so there may need to be some dual entry.
- Increase communication with other Child and Youth Mental Health Services (CYMHS) staff (e.g. daily debriefs on ward).
- Consider involving the Forensic Liaison Officer (FLO) (if available in your Hospital and Health Service (HHS) working with CYMHS populations).
- Consult/involve the **DFV Specialist Health Workforce** if indicated: Contacts and referrals | Queensland Health Intranet
- Conduct regular meetings between all relevant stakeholders to share timely information around the risk profile and agreed response plans.
- Consider the need for a(n):
  - Assessment and Risk Management Committee (ARMC)
  - Police Advice and Intervention Plan (PAIP)
  - Acute Management Plan (AMP)
  - Involuntary Patient and Voluntary High Risk Patient Summary.
- Consultation with Forensic CYMHS (Tier 3).

Trauma reactions and challenges with emotional regulation e.g. anger, impulsivity

- Work with the young person and their family/significant others to:
  - establish a trauma informed therapeutic alliance
  - identify strategies the young person can use to build/enhance their felt sense of safety with the worker
  - provide psychoeducation around the links between trauma and behaviours e.g. hyper/hypo arousal, sexual violence, fire setting, physical violence, threats, aggression
  - work together to develop strategies to identify and manage difficulties with emotional regulation
  - if the young person moves outside of their window of tolerance during sessions use agreed de-escalation strategies
  - collaboratively identify and practice strategies for managing stressors, triggers (e.g. situations, places or people) and/or trauma responses across a range of environments.
- Utilise culturally based intervention frameworks to address any cultural needs e.g. Sorry Business/Sad News, interrupted/unresolved grief, transgenerational and intergenerational trauma.
- Encourage young person to use strategies outside of sessions and monitor progress, reviewing what works and what doesn't and providing positive reinforcement of adaptive behaviour/coping.
- Keep key documents such as Acute Management Plans (AMPs) updated.
- Refer to relevant therapeutic groups if available.

Unclear clinical formulation/diagnostic picture

- Undertake a comprehensive diagnostic assessment, formulation and care planning process.
- Consider the need for an admission to contain the risks until the diagnoses, care plan and treatment (where indicated) is commenced.

Access to potential victims

- Information should be shared with consent wherever safe, possible and practical and with consideration to how the process of obtaining consent may unintendedly increase risk to potential victims e.g. DFV situations. When determining the need to breach confidentiality due to violence risk, the multidisciplinary team (MDT) will need to:
  - carefully consider the **Information sharing in mental health alcohol and other drugs care: Guidance on sharing information** available here: Information sharing | Queensland Health and gather legal advice where possible as every scenario is different
  - in some HHSs the FLO/Mental Health Intervention Coordinator (MHIC) may also be able to assist with these discussions.
- Consider the need for an admission to contain risk and treat the underlying drivers (e.g. if a person has incorporated someone into persecutory delusions).
- Consult with the treating consultant psychiatrist around changes to Limited Community Treatment (LCT) conditions regarding accommodation or location.
- Increase monitoring of the risks via regular reviews and obtaining ongoing collateral around the person's EWS, triggers, stress/coping and foreseeable changes.
- Develop a detailed **victim safety plan** with identified targets for future harm (e.g. early intervention, setting boundaries safely, calling the police if required).
- If safe, recruit a third party who is not a potential target to monitor the person and limit their access to potential victims.
- Contact the Child Protection Liaison Officer (CPLO) if you have welfare concerns regarding a young person or mandatory reporting is required.
- Seek advice from the DFV coordinator for the HHS Contacts and referrals | Queensland Health Intranet.
- Consider a referral to the DFV High Risk Team (HRT).
- Liaise/link with victim support services with consent (e.g. Domestic Violence Action Centre, Domestic and family violence help in Queensland, Home | 1800RESPECT, Queensland Health Victim Support Service | Queensland Health).
- Provide ongoing psychoeducation and relapse prevention/planning with the person around their EWS and triggers, high risk scenarios and foreseeable changes that could lead to violence.
- Where **staff** are identified as potential targets consider the guidance around Occupational Violence (Occupational violence and aggression | Queensland Health Intranet) to develop a risk management plan. You may need to consult with Tier 3 services when there are more complex types of risk i.e. stalking a staff member.

Access to weapons

This may include everyday items e.g. chairs, kitchen knives and legal/illegal items e.g. firearms, crossbows, 3D printed guns, paintball guns, martial arts equipment, explosives, bombs.

Access to weapons/firearms – general information.

For immediate or urgent safety concerns about someone's behaviour or access to a weapon, call Triple Zero (000). For non urgent matters, contact Policelink (131 444) or your local police station.

General considerations

- Continue to consider the person's ongoing access to weapons as part of the routine risk screening process.
- Assist the person to develop insight into the potential risks of having access to weapons.
- Assist the person to address emotional regulation, decision making and attitudes or other factors that influenced them to access weapons with person-centred /relevant psychosocial interventions i.e. cognitive behavioural therapy (CBT), sensory approaches and consider developing a violence safety plan.
- Consider asking the person to remove or reduce access to everyday items used as weapons if feasible and safe to do so.

Access to firearms – this may include legal or illegal firearms, such as 3D printed guns.

Firearms notifications to Queensland Police Service (QPS)

A health practitioner, classified as a 'professional carer' under the Weapons Act 1990, may notify QPS if they are of the opinion that a person is unsuitable to possess a firearm due to a mental or physical condition; or the risk of being a danger to themselves or others.

'Professional carers' are defined as doctors, nurses, psychologists, social workers and professional counsellors. If a health practitioner is from another profession (such as a midwife or occupational therapist) and is of the opinion that a disclosure about a person's suitability to possess a firearm should be made, they should escalate these concerns to a clinician who is a professional carer or the person's broader multidisciplinary care team.

If a person has access to a firearm, refer to the 'Firearms notifications by health practitioners' for information about notification to QPS using the Weapons Notification Form. The information booklet and Weapons Notification Form are both available here: https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health

Health practitioners working for a Hospital and Health Service must notify QPS if they are of the opinion that a person is unsuitable to possess a firearm, using the following steps:

1. complete the Notification to Weapons Licensing form found here: https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health
2. email the completed Weapons Notification Form to QPS and save a copy of the completed notification to the person's relevant clinical records (e.g. CIMHA, ieMR, The Viewer)
3. review/update alerts on all relevant clinical records (e.g. CIMHA, ieMR, The Viewer)
4. although not a routine requirement, consider the need to contact QPS to discuss a collaborative stakeholder plan/establish when they will be able to remove weapons and/or if they can confirm this has occurred e.g. before the person is discharged.

Access to weapons (other than firearms) – this may include everyday items e.g. chairs, kitchen knives and legal/illegal items e.g. crossbows, paintball guns, martial arts equipment, explosives, bombs.

If a health practitioner is concerned that a person has access to a weapon (other than a firearm), disclosure can be made to QPS under section 147 of the Hospital and Health Boards Act 2011 to assist in lessening or preventing a serious risk to life, health or safety, or public safety.

The need for the disclosure must be on reasonable grounds, the risk must be serious, and the disclosure must be necessary to assist in lessening or preventing the risk. The health practitioner also needs written approval from their relevant chief executive, although this power may have been delegated to a local level.

Problems with living situation or homelessness

- Work collaboratively to support the young person and all the people living with them to address any needs, barriers, or risks of their living situation breaking down. Consider a Child Safety report if a young person is homeless/about to become homeless.
- If relevant work on linking other household members with supports e.g. Arafmi (support for mental health carers), Emerging Minds, Carers of Parents with a Mental Illness (COPMI), Carer Gateway, General Practitioner (GP) for a Mental Health Care Plan (MHCP).
- Provide support around basic conflict management to young person and significant others e.g. time out, who to call for individual support e.g. Kids Helpline or Parentline.
- Liaise with accommodation providers about concerns.
- Work with DFV High Risk Team, Department of Housing, NGOs or other relevant agencies in the HHS if the family are at risk of homelessness or require more suitable housing due to overcrowding or other risk factors.
- Assist with referrals to secure alternative accommodation and consider involving a relevant NGO for support.
- Involve supportive people (family/Kin, friends) to identify alternative accommodation options.
- Consider if attachment-based therapy, family therapy, and/or parenting skills programs (Circle of Security, Triple P) are indicated to prevent the young person becoming homeless.

Substance use

- Follow the Co-occurring substance use disorders and other mental health disorders policy.
- Consult with Dovetail (Insight - Toolkits - Dovetail) and/or local youth drug and alcohol services for tailored practice (and referral, if appropriate) advice.
- Use a motivational interviewing, harm reduction and trauma informed approach.
- Provide psychoeducation to the young person (and family/carers if relevant) when ready, willing and able. Assist with making links between substance use and behaviours i.e. violence.
- Based on individual need and the function of the substance use, consider trauma therapy, sensory approaches, narrative therapy, social and emotional wellbeing (SEWB) model or CBT.
- Consider monitoring via self report and/or urine drug screens (UDS).

Poor insight into violence risks

- Using the findings from the VRAM tool, undertake a shared collaborative formulation with the young person and family/carers/supports to assist them to identify or better understand their unique early warning signs, triggers, what maintains behaviours, high risk situations and foreseeable changes, and from there plan adaptive coping responses.
- Where relevant/possible treat aspects of illness impacting insight whilst aways considering developmental stage (e.g. consider medication for depression impacting cognition).

Problems with engagement or adherence with treatment

- Re-assess/identify the reasons and attempt to address the identified needs.
- Provide psychoeducation about the reasons for CYMHS involvement and ways psychosocial or biological interventions can help.
- Involve the young person/family in their care planning, recovery, psychosocial interventions and risk management planning including medication management and monitoring if indicated.
- Work to eliminate any dynamics in which the mental health service is associated with punishment or shame.
- Undertake sessions in conjunction with enjoyable activities where possible e.g. play a simple board game, basketball, walk/talk.
- As appropriate, consider flexibility in meeting environment (e.g. home based outreach, school, Teams).
- Maintain a consistent approach within and between the treating team(s).
- Consider the impact of possible countertransference on the young person's desire to engage with mental health services.
- Provide psychoeducation on and investigate and address any side effects of medication.
- Support physical health by linking with metabolic monitoring.
- Consider the need for admission (in the event of acute risks, high risk scenarios or psychosis/mood is driving risks/poor engagement).
- Offer choice around modes of medication administration (e.g. oral vs depot).
- Consider the need for provisions under the *Mental Health Act 2016*.
- Monitor serum levels, if indicated/available and provide appropriate psychoeducation to support this.

Lack of connection with education

- Collaboratively identify the underlying reasons and work with young person and their family/carers to address the issues.
- Consult with the Ed-LinQ coordinator within Child and Youth Mental Health Service.
- Involve the young person in a referral to alternative learning/training programs (e.g. School of Distance Education, Flexi schools such as BUSY Schools, TAFE).

Parental/carer disengagement

- Identify and address any barriers related to the system/service provision e.g. has the team communicated clearly and in a timely manner; are the opening hours of the service or location a barrier for the person/family; is intergenerational or systemic trauma at play?
- Focus on connection and building a relationship, as well as understanding the reasons for disengagement.
- Consider if the parent/carer is not ready, willing or able and identify strategies to offer them to address the individual needs.
- Ensure all communication is accurate, timely and accessible (e.g. do you need to use an interpreter at all sessions).
- Consider attachment based therapy, family therapy and/or parenting skills programs (Circle of Security, Triple P).
- If there are risks to the young person (and/or other young people in the family) due to a parent/carer not being willing and/or able to protect a young person, consider liaising with local Child Protection Liaison Officer (CPLO) in relation to child safety.
- If the young person does not have capacity to consent to treatment (i.e. Gillick Competence Form Guide Capacity Assessment CYMHS), and a legal guardian appears to lack capacity for any reason, or appears to be experiencing mental health difficulties, explore further team actions that can be taken, using the less restrictive way (Less Restrictive Way Guidelines).

Violent ideation

- Undertake psychoeducation e.g. a chain analysis of violent behaviour to better understand precursors to violence.
- Consider if evidence-based interventions are indicated (if developmentally appropriate).
- Collaboratively develop a relapse prevention plan in relation to violence to build on non violent coping strategies.
- Monitor via serial mental state and risk screen reviews – clearly state required minimum frequency.
- Address underlying drivers e.g. work on trauma, treat symptoms of depression or psychosis.
- Create victim safety plans with individuals identified at risk. Consult/involve the **DFV Specialist Health Workforce** if indicated: Contacts and referrals | Queensland Health Intranet.

Attitudes supportive of violence

- Consider using motivational interviewing to prepare the person to engage in further work (depending on their stage of change).
- Consider the use of CBT and compassion focused therapy to foster victim empathy/perspective taking, cost/benefit analyses including discussing personal consequences of violence (e.g. legal, time, mental health, education, relationship impacts), target emerging core beliefs and identify strategies to manage self talk around violence.

Negative social influences

- Identify sources of negative social influence, both reality based (e.g. peers) and virtual reality based (e.g. internet, violent video games, media reports, social media, apps, influencers, Artificial Intelligence). Monitor closely and implement strategies to minimise exposure or debrief/problem solve around exposure e.g. peer conflict or mass homicide in media.
- Engage in motivational interviewing to encourage behaviour change.
- Encourage parents to limit set around a young person's association with antisocial peers including communication via the internet.
- Engage in psychoeducation and behavioural forecasting with the young person to attempt to increase insight into peer/social influences.
- Explore referrals to recreation and support groups with positive connection.
- Discuss other options for more positive peer contact that can meet their need for connectedness, i.e. sporting or support groups.

Intellectual disability

- If relevant confirm a National Disability Insurance Service (NDIS) support package is in place and meeting the level of need or if re-referral is required if the package is insufficient for the level of need. If not already in place, consider if a NDIS referral is indicated.
- Consider if substitute decision makers are in place or are required and who may be best placed to do this. Consider if an application to Queensland Civil and Administrative Tribunal (QCAT) is required to appoint substitute decision makers if family, Kin, friends or carers are unavailable or unsuitable.
- Undertake an ARMC meeting or liaise with Tier 3 services.
- Consider making a referral to the local HHS Mental Health Intellectual and Developmental Disability Service or liaising with the Queensland Centre of Excellence in Intellectual Disability and Autism Health - Mater.
- Follow the Positive Behaviour Support Plan (PBSP) if available or if indicated request for one to be developed.
- Identify individual communication needs/approaches e.g. communicate in the ways outlined in the PBSP.
- Adapt and tailor interventions based on developmental stage and the cognitive functioning of the person (e.g. communication ability, information processing, attention or memory problems).
- Work closely with family, carers, NDIS, NGO care staff, or other relevant stakeholders.
- Consider the environmental factors e.g. triggers for sensory overload.
- Consider ratio of staff e.g. 2:1 minimum.
- Ensure staff and stakeholders are aware of EWS, triggers and responses to de-escalation and proactively ensure there is a plan for implementation of safety measures by staff.
- Communicate in a calm and considered manner, using short simple sentences, language they understand and avoid arguing or confronting the person.
- Identify high risk scenarios, communicate with staff around these and have an escalation plan in place.
- If staff are potential targets:
  - consider inter positioning by placing a barrier/furniture e.g. a table between the worker and person if they start to escalate
  - work with staff to have an exit plan ready e.g. all exit points identified each shift, have car keys/phone handy, in clinical spaces arrange for security to be onsite
  - identify ahead of time what the threshold is for calling triple zero (000).
- Encourage daily debriefs/handovers with staff and consider if written logs are needed to capture patterns of behaviour including EWS, triggers and so on.
- Establish clear communication pathways between providers and the PSP/treating team.

- Identify relevant training that is available and accessible for care providers or family.
- Consider an AMP and/or PAIP.
- Consider completing a Julian's Key Health Passport | Queensland Health if relevant.
- Ensure regular physical and dental health checks (as medical conditions can escalate behaviours and the person may not be able to communicate this).

Social interaction/communication skills

- Link with social skills groups (if available).
- Provide interventions targeting communication skills and social problem solving.
- Develop confidence via rehearsing/scripting/roleplays in sessions.
- Explore options within the school environment and curriculum (if relevant) to support in enhancing social connection and communication (e.g. extra-curricular school based sporting or arts activities).

Active symptoms of mental illness associated with violence

- When ready, willing and able, provide psychoeducation to the young person and their family/carer around the links between symptoms and their behaviours e.g. violence, property damage.
- Provide skills training in recognising and managing symptoms.
- Refer for long term therapeutic intervention and relevant skills training groups i.e. CBT for psychosis.
- Monitor for the presence, frequency, duration, intensity, severity or increase in symptoms.
- If meets criteria, place on Early Psychosis Care Pathway | Mental Health, Alcohol and Other Drugs Branch.
- Consider the need to have a low threshold for an admission to hospital.
- Review medication.

Rural and remote

- If using telehealth or there are infrequent face-to-face reviews, consider the need to gather collateral from others more frequently e.g. have more frequent communication with family/carers/significant others to aid risk screening of deterioration in mental state and changes to dynamic risk factors.
- There may be a need to include regular communication or care by a Primary Health Clinic or if relevant ATSICCHOs.
- The PAIP needs to be contextualised to support QPS attendance delays if they are not co-located (e.g. responding QPS may be over 100kms away).

Unknown/incomplete data

- PSP to transfer the VRAM tool risk management plan into Care Plan.
- Maintain detailed contemporaneous notes of all risk related information in CIMHA.
- Maintain CIMHA alerts.
- Gather more collateral from relevant personal supports and update formulation and management plan accordingly.
- Gather more collateral from relevant professional supports (e.g. Principal, Guidance Officer (GO)/wellbeing workforce, Teacher Aides/Teachers).
- Gather QPS/Court history from the relevant Youth Justice Service Centre (Department of Youth Justice and Victim Support) or the Queensland Police Service. MHIC may also be able to assist in liaising with QPS.

Protective factors: Example management strategies

Engaged with the service

- Continue to adopt developmentally appropriate, trauma informed, person centred approaches to maintain the alliance/engagement.
- Use a motivational interviewing approach if there are dips in engagement.
- Provide positive reinforcement, affirmations and feedback to the young person and their family around progress they have made/benefits of engagement.
- Continue to involve the person/family/carers in their care planning, recovery and risk management planning.
- Work to eliminate any approaches by the mental health service that could create future barriers to engagement.
- Communicate early and often around any changes that are happening and assertively plan for staff absence or changes in case manager where foreseeable e.g. Case Manager who has good alliance going on annual leave.
- Have a process in place for clear communication/handovers between staff.
- Maintain a consistent approach within and between the treating team(s).
- Offer flexibility in meeting location/environment (as appropriate).
- Celebrate wins and achievements together, no matter how small they may seem.
- Undertake sessions in conjunction with enjoyable activities e.g. play a simple board game, basketball, walk and talk; telehealth-play a game online.

Family/carers engaged

- Maintain strong attachment/bonds where possible by involving the family (with consent) in the treatment/care of the young person.
- Regularly follow up with parents/carers to check in, identify support needs and respond accordingly.
- Support parents/carers with their mental health, carer stress and link with services to avoid burnout e.g. Arafmi, COPMI, Emerging Minds, Carer Gateway, GP for a MHCP.
- Consider the need for parenting groups or family therapy to ensure parents/carers remain engaged.
- Ensure they know who and how to contact with concerns or requests.

Positive relationships with peers, mentors or other community members

- Support the young person in ways to maintain social connections.
- Work with the young person and their family to support positive relationships with peers over a range of environments (e.g. friends visiting at home, placing the young person in classes with their supportive peers, positive online forums or groups).
- Collaboratively revisit and practice strategies for managing interpersonal stressors and conflict across a range of environments i.e. sensory strategies when feeling overwhelmed, deep breathing for feeling a sense of injustice, walk away and go to safe place for conflict.
- Identify any positive teacher/mentor relationships in the school environment and work collaboratively with the young person and the school around ways to maintain this relationship (as appropriate).

Aboriginal and Torres Strait Islander young peoples: Connection to culture, social and emotional wellbeing

It is important to recognise that Aboriginal and Torres Strait Islander peoples' connection to culture is unique to each individual. Taking time to explore and understand what culture means to each young person, and letting it guide an individual's care, is fundamental to supporting their mental health and SEWB. The following considerations may be relevant and will need to be collaboratively explored with the young person.

- From the point of referral for the VRAM tool ensure an integrated approach occurs by considering both the clinical and cultural needs of the young person.
- With consent and where available, include Aboriginal and Torres Islander Health Workers, Practitioners, and/or Hospital Liaison Officers in the person's care.
- Support connection to family and Kin through psychoeducation, yarning, and ensuring Carer/Kin support needs are considered and met where relevant e.g. linking them with an ATSICCHO, and/or other local services.
- Support the young person to engage in cultural practices e.g. traditional art/craft, music, dance, yarning and storytelling, hunting and fishing, community groups, land councils, cultural programs.
- Assist the young person to carry out cultural roles and responsibilities, including minimising the impact of treatment and care where possible (e.g. offering flexibility around leave and appointments, particularly during times of Sorry Business/Sad News, ceremony, or other cultural obligations).
- Support connection to community events and celebrations (e.g. National Aboriginal and Islanders Day Observance Committee (NAIDOC), National Reconciliation Week (NRW), Coming of the Light).
- With consent, respectfully engage community Elders to support the young person's recovery and cultural needs.
- Facilitate connection to land and Country and support the young person to maintain this connection during absences e.g. facilitate access to natural environments or exploring whether meaningful objects from Country can accompany the person during inpatient care.
- Support the young person's connection to spirit, spirituality, and ancestors e.g. providing space and opportunity for smoking ceremonies, supporting the use of traditional healing practices or traditional medicines where safe and appropriate.
- Ensure care plans are holistic and consider co-occurring physical health needs, recognising that physical, emotional, spiritual, and cultural wellbeing are interconnected and integral to recovery.

Stress and coping deficits

- Use a motivational interviewing and person centred approach, positioning the young person as an expert in their own lives, with agency and autonomy.
- Regularly engage in open conversations to collaboratively explore problems, stressors or foreseeable changes and support and guide the young person with identifying adaptive ways to manage these as they arise.
- Affirm adaptive internal and external coping strategies.
- Assist the young person to proactively monitor their stressors, coping response/strategies and to look for additional /alternative social supports if they are to break down.
- If relevant undertake safety planning with the young person and their significant others and key stakeholders i.e. school.
- Expand the young person's repertoire of strategies by introducing relevant/suitable self directed strategies (e.g. sensory approaches, deep breathing, using apps, help seeking).

Commitment to school/education

- Ensure any support plans are tailored to the education environment and communicated with all identified key school/education staff and that these are reviewed and updated regularly.
- Support the young person in setting goals related to the education environment (work to make these SMART) and acknowledge, validate and celebrate achievements.
- Continue regular stakeholder meetings.
- Link school with Ed-LinQ coordinator (https://www.childrens.health.qld.gov.au/our-work/statewide-ed-linq-program) to support in identifying key school staff/stakeholders, provide consultation, liaison, mental health and wellbeing training and education to school staff, and enhance and enable communication between school and CYMHS.
- Link with mentors or wellbeing support/staff programs available via their education provider (i.e. TAFE) or employer.
- Maintain school engagement by exploring (if indicated) alternative schooling options (e.g. Flexi schools, School of Distance Education).

Engages in positive activities

- Maintain/encourage active participation in positive activities (e.g. sports, clubs, hobbies) during case management, consider using a mentor and/or linking with relevant groups in the area of interest.
- Explore the possibility of expanding current activities (e.g. engaging in part time work, volunteering)
- Identify financially sustainable options (e.g. Police Citizens Youth Clubs (PCYC) discounted memberships or free access to PCYC run groups or headspace i.e. Dungeons and Dragons).

This document was developed in consultation with Queensland Health forensic mental health and mental health and other drugs services clinicians.

Further training: Queensland Centre for Mental Health Learning

The **Learning Centre** has a number of additional **training** options related to specific practice frameworks or approaches referred to in the QC30 workshop (such as the 5 Ps and risk status/risk state), including the following:

Course code	Course name	Modality
QC9/QC33	Critical Components of Risk Assessment and Management (aimed at Tier 1)	Workshop (Face-to-face or online classroom)
QC14/QC34	Fundamentals of Assessment, Formulation and Planning	Workshop (Face-to-face or online classroom)
QC19	Risk Refresher	Online classroom
QC36	Capacity Assessment and Advance Health Directives	Online classroom
QC40	Capacity Assessment and Advance Health Directives	eLearning
11362NAT	Course in Observing and Documenting the Mental State Examination (note this is a nationally accredited course)	Workshop (Face-to-face or online classroom)
QC48	Mental State Examination	eLearning
QC49	Police Advice and Intervention Plan	eLearning
QC53	Capacity Assessment and the ‘Less Restrictive Way’ for Minors	eLearning
QC54	Foundations of Risk Assessment and Management	eLearning
QC55	Formulation and Care Planning	eLearning
QC57	Introduction to Violence Risk Assessment and Management	eLearning

Resources

MHAOD Branch and comprehensive care resources

Assessing and Responding to Violence (ARV) Framework	The link to the full ARV Framework was not available at time of publishing. <<TO BE CONFIRMED>>	QHEPS only access
Assessing and Responding to Violence (ARV) Framework poster	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0022/3186301/assessing-and-responding-violence-framework-poster.pdf	QHEPS only access
Firearms notification booklet and form	https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health	
Information sharing	https://www.health.qld.gov.au/public-health/topics/mhaod/for-healthcare-providers/clinical-guidelines-policies-and-resources/information-sharing	
Recognising and responding to risk in mental health, alcohol and other drug service (MHAODS) website	https://qheps.health.qld.gov.au/mentalhealth/resources-and-guidance/recognising-and-responding-to-risk	
Chief Psychiatrist Policy: Treatment and care of patients subject to a treatment support or forensic order or other identified higher risk patients	https://www.health.qld.gov.au/__data/assets/pdf_file/0028/635932/cpp-forensic-policy.pdf	
Chief Psychiatrist Policy: Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the MHA 2016	https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465212/cpp-notific-critical-incidence.pdf	
Substance use	https://www.health.qld.gov.au/__data/assets/pdf_file/0023/1118246/qh-gdl-964.pdf	
Comprehensive Care	https://qheps.health.qld.gov.au/mentalhealth/resources-and-guidance/clinicaldocs	
Comprehensive Care VRAM Guide	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0035/2595392/guide-vram.pdf	QHEPS only access

Domestic and family violence (DFV) resources		
DFV – Main site, including how to access DFV training ***Highly recommended to complete**	https://qheps.health.qld.gov.au/system-policy-planning/branches/system-policy/social-and-primary-care-policy-unit/domestic-and-family-violence	QHEPS only access
DFV – contacts for each HHS	https://qheps.health.qld.gov.au/system-policy-planning/branches/system-policy/social-and-primary-care-policy-unit/domestic-and-family-violence/contacts-referrals	QHEPS only access
DFV – QH Training, including victim assessment, support and safety ***Highly recommended to complete**	https://qheps.health.qld.gov.au/system-policy-planning/branches/system-policy/social-and-primary-care-policy-unit/domestic-and-family-violence/DFV-capability-framework	QHEPS only access
DFV – Common Risk and Safety Framework (CRASF) ***Highly recommended reading**	https://www.families.qld.gov.au/our-work/domestic-family-sexual-violence/for-service-providers/integrated-service-responses/dfv-common-risk-safety-framework/risk-assessment-safety-planning-tools	
DFV Referral Model ***Highly recommended reading**	https://www.health.qld.gov.au/__data/assets/pdf_file/0021/465132/dv-referral-model.pdf	
DFV – Microlearning videos	https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence-resources	
DFV Information Sharing Guidelines	https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/f324d93d-1777-47a1-aa52-2bf4140b6d0f/dfv-information-sharing-guidelines.pdf?ETag=69d0b70da334e29361e40e12f56cfda2	
Occupational violence resource		
Aggression towards staff guidance	https://www.worksafe.qld.gov.au/safety-and-prevention/mental-health/Psychosocial-hazards/violence	

Aboriginal and Torres Strait Islander Peoples resources

The following resources are to be used in consultation with Aboriginal and Torres Strait Islander Health Workers, Practitioners, and/or Hospital Liaison Officers.		
Forensic risk integrated formulation: Aboriginal and Torres Strait Islander cultural consideration prompts.	https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/CHQ-ATorresCultural-FW-FRIAF.pdf?forcedownload=1	
Cultural Mental State Examination: Aboriginal and Torres Strait Islander cultural consideration prompts.	https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Cultural%20MSE%20Wheel.pdf?forcedownload=1	
MHPOD: Honouring Aboriginal and Torres Strait Islander voices in healing family violence.	https://www.mhpod.gov.au/	
Child and youth resource		
School-based violence prevention: A practical handbook.	https://iris.who.int/server/api/core/bitstreams/9971db81-2451-4a8c-9511-84ad9d196a4a/content	
Acute violence risk resource		
Approaches to managing acute behavioural disturbance.	https://tgldcdp.tg.org.au/viewTopic?etgAccess=true&guidelinePage=Psychotropic&topicfile=approach-acute-behavioural-disturbance	
Trauma informed training		
Trauma Informed Care eLearning ***Highly recommended to complete**	https://insight.qld.edu.au/toolkits/trauma-informed-care/detail	
Integrated formulation training		
Integrated formulation: Overview and examples **Comprehensive care** *Highly recommended to review	https://insight.qld.edu.au/shop/integrated-formulation-overview-and-examples	

Example VRAM tools

Training VRAM tools: FULL EXAMPLES		
Peter VRAM Tool	https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Peter%20VRAM%20full%20example.pdf?forcedownload=1	
Luke VRAM Tool	https://www.qcmhl.qld.edu.au/pluginfile.php/44904/mod_folder/content/0/course/resources/QC30/Luke%20VRAM%20full%20example.pdf?forcedownload=1	
VRAM tools: FICTIONAL EXAMPLES		
Adult VRAM tool examples and Child and youth VRAM tool examples	Course: RE11 Violence Prevention Resources	

Contact the Learning Centre

Phone: 3542 2111

Email: qcmhltraining@health.qld.gov.au

Learning Management System: www.qcmhl.qld.edu.au

Address: Anderson House, Corner Court Road and Ellerton Drive, Wacol, Qld 4076.

Key services/Contact details

Statewide specialist support services	
DFV - Contacts HHSs	https://qheps.health.qld.gov.au/system-policy-planning/branches/system-policy/social-and-primary-care-policy-unit/domestic-and-family-violence/contacts-referrals
Queensland Transcultural Mental Health Centre	https://www.qld.gov.au/health/services/specialists/queensland-transcultural-mental-health-centre
Cultural consultants	https://www.health.qld.gov.au/public-health/groups/multicultural/contacts/mental-health
Contact details for ATSICCHOs	https://www.naccho.org.au/aboriginal-community-controlled-health/
Deafness and mental health	https://www.qld.gov.au/health/services/specialists/deafness-and-mental-health-services
Statewide Ed-LinQ Program | Children's Health Queensland	https://www.childrens.health.qld.gov.au/our-work/statewide-ed-linq-program
Tier 3 Services	
Community Forensic Outreach Service (CFOS) for Brisbane, Townsville, Cairns	https://qheps.health.qld.gov.au/qfmhs/community-forensic-outreach-service
Forensic CYMHS for Brisbane, SEQ up to Rockhampton	https://www.childrens.health.qld.gov.au/our-work/forensic-child-and-youth-mental-health-services
Forensic CYMHS for Townsville and Mackay (and out to the borders)	https://www.townsville.health.qld.gov.au/services/mental-health/cayas/north-queensland-adolescent-forensic-mental-health-services/
Forensic CYMHS for Cairns and TCHHS	https://www.cairns-hinterland.healt h.qld.gov.au/services/child-and-youth-mental-health