Violence Risk Assessment and Management Guide Version 1
(King, 2023)

Cite form as:

King, C. M. (2023). *Violence Risk Assessment and Management Guide* [Version 1, Unpublished work]. Psychology Department, Montclair State University.

Usage notes:

This form-based and flexible guide, the VRAM G[v1], was heavily inspired by the *Linehan Risk Assessment & Management Protocol* (LRAMP; Linehan, 2016); other major sources of inspiration are provided in the reference list below. The form is organized into the following sections: reason(s) for completing the form; violence risk assessment actions; violence risk management/reduction actions; final opinions regarding violence risk and any protective actions; additional summary and notes; and certification of completion. The form is most applicable to non-medical behavioral health providers, especially psychologists, and focuses on targeted threat scenarios rather than abuse and neglect and forensic evaluation scenarios. The form is meant to serve as a synthesized resource for training purposes, with users referring to the below references, other sources, and their supervisors for further professional guidance (see King et al., in press). The form is not a validated violence risk assessment nor management tool. Contact Christopher M. King, JD, PhD, at **kingch@montclair.edu** for permission to use.

Special notes about the Violence Risk Assessment section of the form:

Examples of *structured risk assessment tools* for different violent outcomes of concern, and their included risk and protective factors, are available in Douglas and Otto (2021). When circumstances permit, use of these tools is recommended, for appending to this section.

If circumstances warrant assessing violence risk via *unstructured professional/clinical judgment* (Monahan & Skeem, 2014; Wortzel, Borges, Barnes, et al., 2020), risk and protective factors may be drawn from meta-analyses of risk factors for different violence outcomes (e.g., Fazel et al., 2018); recommendations for factors for threat assessment (e.g., Borum and Reddy, 2001; Mitchell & Palk, 2016); and record forms for violence risk and protective assessment tools (e.g., Douglas et al., 2013; SAPROF International, 2018a, 2018b). For example, risk factors in the domains of biological; historical; family, social, and environmental; clinical conditions, symptoms, and stressors; attitudes and emotions; capacities (e.g., access to weapons and victims); planning; intent; and non-responsiveness to risk reduction strategies (Almvik et al., 2000; Borum and Reddy, 2001; Fazel et al., 2018). And protective factors in the domains of internal traits and resilience, attitudes and motivation, and social and other external supports or circumstances (SAPROF International, 2018a, 2018b). However, it should be noted that proceeding in this way in not commensurate with the structured professional judgment nor actuarial approaches (e.g., Wortzel, Borges, McGarity, et al., 2020). This includes because unstructured clinical judgment does not entail use of a predetermined list of risk and protective factors to consider, nor standardized operationalization of those factors, nor statistical comparison to reference groups (e.g., Hart & Douglas, 2023). Such that the uncertain reliability

and validity of this approach must be acknowledged in general, and the bearing of this in the individual case at hand.

For guidance conducting an *anamnestic assessment*, refer to Otto (2000); for guidance conducting a *functional (chain) analysis* relevant to other-directed violence risk, refer to Borges et al. (2021). See also Eckhardt et al. (2014) for further ideas about conceptualizing the influence of risk and protective factors.

Risk and protective factors, and overall risk, may be *conceptualized* in summary form in terms of *applicability* (e.g., no, somewhat or mixed, appreciably or clearly); hypothesized *functional relevance* to risk of a violent outcome (e.g., no, possible, clearly) or risk management/reduction (e.g., critical, prioritized target for reduction); and *level* (e.g., low, moderate, high; Douglas et al., 2013; SAPROF International, 2018a, 2018b; Wortzel, Barnes, et al., 2020). It is further recommended that users attend to the anticipated nature or type of violence; probable victim or victims; and likelihood, severity, and imminence of violence (Heilbrun et al., 2021; SAPROF International, 2018a, 2018b). Attaching a *narrative* conceptualization (probable story) concerning violence risk is also advisable; such can also be incorporated into the final section of this form.

Summaries of strategies reflected in the Violence Risk Management/Reduction section of the form:

The specific risk management strategies in the form are organized into the subsections of functional analysis (e.g., chain and solution analysis), crisis intervention and de-escalation strategies, increased social support, referral or conferral, contraindications for inpatient management, emergency protection actions, and other. To help recall general themes or categories of strategies that might be employed in the moment with or concerning clients, the following two complementary summaries are offered.

***Summary 1*:** general prevention/personal safety awareness; safety planning (including with respect to weapons); treatments; de-escalation (non-verbal, verbal, involve others, other); assertiveness, distancing, and other crisis management; inpatient/emergency referral; warn others

***Summary 2*:** proactive; discreet; cautious, prepared, and aware; calm, confident, clear, and assertive; concerned, compassionate, and empathic; collaborative and creative; relieving; psychological and psychiatric interventions

An important note is offered about diversity and multiculturally sensitivity. Consistent with recommendations in the research and professional literature (Hallett & Dickens, 2017; Kleespies et al., 2023), one of the violence risk management strategies in the form is, “Remained attentive to client and clincian’s non-verbal/verbal behavior and cultural factors.” While this item is currently organized under the domain of crisis interventions and de-escalation strategies, consistent with broader sources of authority within the human services disciplines (e.g., American Psychological Association, 2017), it should be understood as applicable generally to both guides in their entirety.

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VRAM G^{v1} (King, 2023)

Client: _____ **Date of contact:** _____

Completed by/signed: _____ **Date completed:** _____

1. REASON FOR USING FORM

Completing form because of:

- ☐ **History** of violent ideation/urges/intent, preparation or attempts, or behavior at intake
- ☐ **First or new report** of violent ideation/urges/intent, preparation or attempts, or behavior
- ☐ **Increased** violent **ideation/urges/intent**, or **other communication, behavior, or circumstances** indicating increased violence risk since last contact
- ☐ **Violence attempted or carried out since last contact**
- ☐ **Violence attempted, occurred, or ongoing during contact**
- ☐ **Other:**

Description of prompting concerns:

2. VIOLENCE RISK ASSESSMENT

Assessment of violence risk was:

- ☐ **Conducted**
- ☐ **Not conducted** because:
  - ☐ **Clinical justifications:**
    - ☐ **Previous risk assessment** recently completed
    - ☐ Only **usual/baseline indicators** for client not typically associated with increased imminent risk for violence
    - ☐ **No or negligible** violent ideation/urges/intent **at start** of contact, impulse control appeared adequate and sufficient protective factors present, and no or negligible new risk factors apparent
    - ☐ Violent ideation/urges/intent **conceptualized functionally** (e.g., escape/avoidance, reinforcement, other contingencies) and treatment needs were better accomplished by working to manage these influences rather than by conducting formal risk assessment
    - ☐ **No or negligible** violent ideation/urges/intent **by end** of contact, impulse control appeared adequate and sufficient protective factors present, and no or negligible new risk factors apparent
    - ☐ Client is in treatment with **another primary clinician** who recently or soon will assess and mange violence risk; would not be helpful for two clinicians to address
    - ☐ Violence threat or action was **superficial/minor** (e.g., clenched fist and glare, gentle push or grab) per the reports of all involved and followed by inhibitors of recurrence; circumstances appropriate to target other priority treatment needs instead
  - ☐ **Referred** client to another clinician/supervisor for risk assessment
  - ☐ **Forgot**; will follow up on: _____
  - ☐ **Other:** [ ]

Assessed risk for:

- ☐ **Any** interpersonal violence
- ☐ **Intimate partner** violence
- ☐ **Sexual** violence
- ☐ **Homicide**
- ☐ **Targeted threat**
- ☐ **Other** outcome (e.g., verbal hostility, antisocial behavior): _____

Approach used to assess violence risk:

- ☐ **Structured professional judgement** tool(s): _____
- ☐ **Actuarial** tool(s): _____
- ☐ **Anamnestic** (functional analysis)
- ☐ **Unstructured professional/clinical judgment**

Factors assessed (attached additional pages as necessary):

- ☐ Risk/protective assessment tool(s) **rating/record form(s) attached AND / OR**
- ☐ Indicated **below** with **notes attached** about presence and relevance to risk or risk management/reduction

RISK	PROTECTIVE

Potential violence scenarios:

Type(s) of violence posed	
Target(s)	
Degree of harm posed	
Probability of violence	
Timeframe/how soon	

Type(s) of violence posed	
Target(s)	
Degree of harm posed	
Probability of violence	
Timeframe/how soon	

Type(s) of violence posed	
Target(s)	
Degree of harm posed	
Probability of violence	
Timeframe/how soon	

3. VIOLENCE RISK MANAGEMENT/REDUCTION

Treatment actions taken to reduce or manage violence risk:

- ☐ Violent ideation/urges/intent, behavior, and circumstances **not explicitly targeted** during contact because:
  - ☐ **Same reasons** as for not conducting assessment
  - ☐ Client's **violence risk is not sufficiently likely nor imminent**
  - ☐ **Risk assessment** had sufficient risk-reducing effects
  - ☐ **Other:** _____

- ☐ **Functional analysis/anamnestic assessment of prior/recent/current** violent ideation/urges/intent, behaviors, and circumstances:
  - ☐ Impelling (risk increasing) **vulnerability factors**
  - ☐ Instigating (risk soliciting) **prompting event**
  - ☐ Impelling (risk increasing) and inhibiting (risk buffering) **links** (thoughts, feelings, body sensations, behaviors, events)
  - ☐ **Target behavior**:
    - ☐ Increased violent ideation/urges/intent
    - ☐ Expressed or leaked indicators of violence threat
    - ☐ Attempted violence
    - ☐ Violent behavior
    - ☐ Other: _____

- ☐ **Crisis interventions and de-escalation strategies**
  - ☐ Arranged for **environmental safety/calmness** and **clinician's own personal safety/relative anonymity**
  - ☐ Sought and **reviewed other information** about client, or **conferred with others** about them
  - ☐ Remained attentive to client and clinician's **non-verbal/verbal behavior** and **cultural factors**
  - ☐ Managed **clinician's own emotional expressions/urges**
  - ☐ Stressed clinician's **helpful/peaceful intentions**
  - ☐ Arranged for **increased client comfort/decreased stimulation**

- ☐ Redirected client to **other interests or objectives**
- ☐ **Validated** client's current emotions or preferences
- ☐ Appropriately **transparent** with client
- ☐ **Formulated or reframed** problem situation and **summarized** to client
- ☐ Explored and noted **matters** that remained **in client's control**
- ☐ **Brainstormed** with client and **offered non-violent solutions/advice** to reduce risk factors/increase protective factors
- ☐ **Identified and worked to resolve** instigating **prompting events** for current presentation
- ☐ **Challenged problematic thoughts/beliefs** related to violence
- ☐ **Coached** client **to use techniques** to decrease risk factors/increase protective factors
- ☐ **Clarified and reinforced** potential adaptive responses/protective strategies
- ☐ **Satisfied** client's **reasonable demands**
- ☐ **Took a break** or **discontinued** the interaction
- ☐ Engaged in **reasonable physical self-defense**
- ☐ Developed, reviewed, or updated **safety plan**, and obtained client's **agreement**
- ☐ **Troubleshot factors** that might interfere with safety plan
- ☐ **Told client firmly** about limits and to not engage in violence
- ☐ Obtained client's **commitment to no violence** until: _____
- ☐ Obtained client's **commitment for weapons/means removal or reduced ready access**, or otherwise arranged for removal/removed:

Types:	
By whom:	
How:	

- ☐ **Increased social support**
  - ☐ Planned for **client to contact social supports** (whom):
  - ☐ **Alerted social supports** to risk with client consent (describe):

☐ Scheduled **check-in contact** for: _____

☐ **Referred** to, **involved**, or **conferred** with:

☐ Primary clinician: _____

☐ On-call clinician/supervisor: _____

☐ Other appropriate professional: _____

☐ Crisis line for which client given phone number: _____

☐ Other:

☐ **Other treatment actions:**

4. ULTIMATE VIOLENCE RISK OPINION AND DISPOSITION

I believe, based on the information available to me that:

☐ Emergency protective actions are not currently necessary because client's risk of violence to others is **not sufficiently severe nor imminent** and client is **not sufficiently likely** to engage in violence until the next contact with me or another treating clinician because:

- ☐ Factors contributing to violence risk are being actively resolved by client and me or another primary clinician
- ☐ Violent ideation/urges/intent sufficiently low or reduced by end of contact
- ☐ Adequate safety plan agreed to by client, including commitment to no violence
- ☐ Sufficient inhibiting effects of identified protective factors
- ☐ Other: _____

☐ There is **significant uncertainty as to client's risk of violence** to others; I will get a **second opinion** from:

- ☐ Supervisor: _____
- ☐ Primary clinician or another responsible clinician: _____
- ☐ Other appropriate colleague or staff member: _____
- ☐ Other: _____

☐ **Inpatient treatment considered but determined to be infeasible or contraindicated** because:

- ☐ Client **does not reach threshold for involuntary inpatient evaluation/treatment**
- ☐ Client **can readily contact me** if their risk increases, which client committed to do
- ☐ **Other environmental supports** available
- ☐ **Optional voluntary inpatient evaluation/treatment would have appreciable consequences** for client (e.g., isolation, stigma, school, work, financial, agreed-to safety plan) that client committed to avoiding via maintenance of safety
- ☐ **Client refused** optional voluntary inpatient evaluation/treatment **despite my firm arguments** for this course of action

☐ **Client's risk shared with appropriate others** (e.g., potential victim; law enforcement; client's other providers, family, or friends; victim's family or friends), which is believed to be sufficient to maintain safety

☐ **Emergency protection actions are needed to warn of and protect from client's violence risk to others (when, how, and of what):**

☐ **ALERTED intended victim(s)** of client's imminent violence risk:

☐ **ALERTED law enforcement** (community, e.g., called 911) or **clinical and security staff** (inpatient, e.g., called code) of client's imminent violence risk

☐ **ALERTED victim's social supports** of client's imminent violence risk (community):

☐ **ALERTED client's social supports** of client's imminent violence risk (community):

☐ **ALERTED other appropriate persons**:

☐ **ARRANGED** for **wellness check by law enforcement** (called 911) or observation by **clinical and security staff** (inpatient, e.g., 1:1 observer):

☐ **ARRANGED** for further evaluation and management at **hospital emergency department** or **other crisis screening location** (community):

☐ **ARRANGED** for **other outreach evaluation** (community):

☐ **ARRANGED** for further evaluation/management by a **more senior clinician, or other clinical specialty** (e.g., psychiatry) having special management strategies (inpatient admission, medication, physical restraints):

☐ Other:

Client will be reevaluated for violence risk toward others within or at the next:

☐ ___ hours via:

☐ ___ days via:

☐ Individual session

☐ Group session

☐ Pharmacotherapy session

☐ Referred outpatient mental health provider(s) contact (outpatient)

☐ Referred emergency department, crisis screening, or outreach contact (outpatient)

☐ Prior to discharge (inpatient)

☐ First referred follow-up appointment post-discharge (inpatient)

☐ No referred or follow-up evaluation or intervention is currently necessary

☐ Other:

5. ADDITIONAL SUMMARY, NOTES, OR ATTACHMENTS