

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR**

**2.5 PARAMETERS FOR ASSESSMENT AND MANAGEMENT OF CLIENTS AT RISK FOR
DANGER TO OTHERS**

Revised July 2014

I. INITIAL CONTACT

A. Screening: Upon first telephone or face-to-face contact, intake workers should make efforts to determine the urgency for clinical contact based upon the client's:

1. Level of emotional distress, (e.g., rage,)
2. Recent behavior, (e.g., current intoxication,)
3. Content of statements, (e.g., homicidal thoughts or thoughts of harming self, others or property,)
4. Nature of situation described, and
5. Nature of service request.

B. Transfer to a Clinician:

1. Expression or description of violent thoughts, plans, statements or actions by a client or other informant should be immediately documented and referred to a designated clinician (e.g., Officer of the Day)
2. The person initially handling the contact in which information of potential dangerousness is disclosed should make every effort to get the exact name of the client or informant, telephone number, address, and current location before transferring to a clinician. In instances where the client refuses to give identifying information, the transfer should be delayed.

C. Maintaining Safety: Reasonable precautions should exist for working with potentially violent individuals and should include:

1. Provision of ongoing training on elements of workplace safety e.g., weapon management and how to deal with an agitated or threatening client. [See DMH Illness and Injury Protection Plan \(IIPP\) Chapter 8.](#)
2. Maintenance of a safe interviewing environment, (e.g., availability of alarms, exits and backup assistance, and absence of dangerous objects.) [See DMH IIPP, Chapter 8.](#)

D. Information Provided by an Informant: Statements by an informant about a client's recent or past history of potentially violent ideation, statements or behavior should always be documented and considered seriously in assessing risk even though the informant may be anonymous or may contradict the client's statements or be denied by the client.

E. Initial Clinical Contact:

1. Screening for intent to harm self, others or property should be part of every initial clinical telephone or face-to-face contact.
2. When indicated by screening, the designated clinician should perform and document an emergency assessment in order to ascertain the presence of a threshold risk and need for emergency management. For purposes of these parameters, a threshold risk is defined as the identification of a client's risk of harm to others from a clinical assessment

in which a homicidal or other threat has been made and/or threatening behaviors have been identified that appear to pose a serious threat of physical violence and imminent danger to others. The threat is clear, specific, and plausible.

3. When the assessment of a caller indicates there is a threshold risk of immediate danger, another staff or supervisor should be alerted to contact the police while the clinician continues to engage the client by phone.

F. Employees Who Receive Threats: Employees Who Receive Threats should immediately notify their supervisor, and the Health & Safety Officer, and submit a Security Incident Report (SIR). [DMH Policy 308.01 SECURITY/SAFETY/VIOLENCE PREVENTION](#)

II. EMERGENCY DANGER TO OTHERS RISK ASSESSMENT

A. Components: An Emergency Danger to Others Risk Assessment should include:

1. The reason the client has contacted the agency or otherwise came to the agency's attention,
2. The specific nature of help the client, or person referring the client, desires (or refusal of help,)
3. The presence of specific external sources of stress, including job, school, relationship loss/changes, or victimization history such as recent humiliating life event, bullying, and/or recent sense of being treated unfairly,
4. The degree to which the client experiences frustration, and/or anger, and the presence of overt hostility,
5. Nature of violent thoughts, statements or plans,
6. Practicality, specificity and lethality of plans (including availability of weapons and specificity, identification and proximity of intended victim[s],)
7. Preoccupation with firearms or other weapons,
8. Nature and timeframe of previous acts of violent behavior involving self, others or property, including the presence of a pattern of escalation of violent thoughts or behavior towards a specific individual or other people,
9. The presence of reasons for a client or informant to exaggerate or understate concerns about potential violence,
10. Evidence of other mental symptoms and disorders, especially those involving paranoid delusions, violent command hallucinations, and other psychoses, antisocial, and borderline personality disorders, disorders of impulse control, conduct disorders, despondency, loss of self-esteem, alienation, agitation, and anger,
11. Evidence of substance-related pathology: intoxication, recent drug or alcohol use,
12. Negative reaction to suggested treatments,
13. Protective factors, (e.g. availability of a strong family support, parents/children/dependents,) and
14. Awareness of possible signs of antecedents of violence and or agitation that may signify impending risk.

B. Determination of Level of Risk:

1. The emergency risk assessment should clearly document the clinician's assessment of the level of dangerousness described as low, moderate, or threshold.
2. The basis for determination, (e.g. history, behavioral observations, statements of the

client or significant others.)

C. Emergency Risk Assessment Follow-Up: After an emergency risk assessment the clinician may:

1. Evaluate the client to determine if he/she meets criteria in order to be taken into 5150 or 5585.55 custody,
2. Seek timely relevant consultations, including medication assessment,
3. Initiate a full clinical assessment,
4. Schedule the client for additional assessment and a follow up appointment, or
5. Refer the client to appropriate departmental and/or community resources.
(For FSP Clients, also Attachment 1: FSP Guidelines for the Assessment and Management of Clients at Risk for Violence.)

D. Involvement of Others/ Safety Issues/ Confidentiality:

1. Significant others should be notified and engaged to provide support and limit access to potential weapons as clinically indicated and permitted by statutes, policies and procedures regarding confidentiality.
2. In the case of minors, parents/guardians should be notified and engaged to limit access to potential weapons and provide an appropriate level of supervision, support, and guidance in problem solving and conflict resolution.
3. When consent is not possible and a client is at risk of committing violent acts, the clinician should limit the disclosure of confidential information to only that which is necessary to obtain emergency intervention in order to save life.
4. For serious threats to a reasonably identifiable/foreseeable victim or victims, Law enforcement) and intended victims should be notified as required by law and an evaluation for involuntary detention should be initiated under CA WIC 5150. (See DMH POLICY 202.02 DUTY TO WARN AND PROTECT.)

III. COMPREHENSIVE DANGER TO OTHERS RISK ASSESSMENT

A. Indications:

1. A comprehensive assessment should be completed for clients:
 - a. Who have recently made threats or attempted violence towards others,
 - b. Express or admit to violent thoughts and or intentions,
 - c. Who demonstrate threatening behavior, or
 - d. When a third party has indicated the possibility of violent behavior.
2. Comprehensive clinical assessment for clients believed at risk for potentially violent behavior should be expeditiously initiated, and should be regularly evaluated for as long as clinically indicated.

B. Documentation: The comprehensive assessment should be completely documented in the medical record and danger to others-related components of the assessment should be easily found and prominently noted when a threshold risk is present.

C. Components:

1. Comprehensive assessment should at minimum include the complete evaluation for

mental disorders and acute stressors performed at the agency in which the client has sought and been offered services.

2. The comprehensive assessment should specifically include known factors that affect risk of committing violence, including:
 - a. Factors 1-14 in the emergency risk assessment, (Section II. A)
 - b. Compliance with suggested interventions (including medication compliance) since the emergency assessment,
 - c. Any changes in the client's situation or actions by the client since the emergency assessment.

D. Assessment of Lethality: Assessment should include, to the extent possible, factors in the client's physical and psychosocial environment that may increase the risk of violent behavior, (e.g., presence of weapons, or loss of job or significant others.)

E. Assessment Summary: The assessment should clearly document the estimated degree of risk of danger to others present, stated as low, moderate or threshold risk and the basis for determination, (e.g. history, behavioral observations, statements.)

F. Treatment Plan Documentation: The treatment plan derived from the assessment should document the manner in which the estimation was derived, the manner in which the degree of risk of danger to others has influenced the treatment plan and any specific measures taken to decrease the risk of violence.

G. Measurement of Risk: Specific instruments to measure risk of danger to others (e.g., the HCR-20 [Historical, Clinical Risk Management Scale],) if used, should be interpreted by qualified clinicians, and should only be used as an adjunct to competent clinical assessment. When the assessment of risk of danger to others differs from that of a previous assessment, the change should be explicitly noted, the reasons determined, and the manner in which the change affects treatment (or why treatment remains unchanged) should be documented.

H. Involvement of Others:

1. Within the limits of confidentiality, significant others should be notified of assessed risk of danger to others and their help enlisted when clinically indicated.
2. For a threshold risk , i.e. serious threat to a reasonably identifiable/foreseeable victim of victims, law enforcement, and intended victims should be notified as required by law and an evaluation for involuntary detention should be initiated under CA WIC 5150.

IV. MANAGEMENT OF CLIENTS AT RISK FOR DANGER TO OTHERS

A. Reassessment:

1. Clients at risk for potential violence should be regularly reassessed to determine changes in the degree of risk and treatment plans should be adjusted accordingly.
2. The client's environment should be continually reassessed to the extent practical to detect and mitigate risk factors, (e.g., firearms.)

B. Involuntary Hospitalization: Evaluation for -Involuntary hospitalization should be immediately implemented for clients at a threshold, i.e. or serious risk of danger to others.

C. Engagement of Support System: Within the limits of confidentiality, the client's support system should be kept apprised of the client's risk of danger to others, and their help should be enlisted whenever clinically appropriate.

D. Pharmacological Interventions:

1. Short-term psychopharmacologic agents may be administered when the client is acting in a seriously threatening manner, towards self or others. Choice of medication includes rapid-acting antipsychotic, antianxiety and sedative medications that are likely to most quickly establish impulse control. Monitoring by staff for effects on respiration, blood pressure, pulse rate, and level of consciousness are imperative.
2. Long-term use of drugs to manage aggressive behavior should occur only as a component of a treatment plan that is based upon a comprehensive history, complete diagnosis, and consideration of a full range of psychological, social and environmental interventions. Prior treatment experience, substance abuse, and diagnostic precision should guide physicians regarding the appropriate medication.

E. Crisis management and Safety-planning Interventions: Essential interventions for clients at risk of danger to others include:

1. Explorations of alternatives to violence as a viable option,
2. Strengthening social supports,
3. Increasing ability to cope with loss, change, the triggering situation,
4. Anger and stress management, and
5. Counseling for client and significant others regarding limitation of the availability of potential weapons to decrease potential for deadly impulsive actions.

F. Emergency Support System: Clients at risk of danger to others should be provided with a 24/7 method of establishing contact with mental health resources that can effectively intervene when necessary to decrease risk of danger to others.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FSP Guidelines for the Assessment and Management of Clients at Risk for Violence

Assessment of At- Risk Behaviors

A review of research identified relevant dispositional, historical and situational risk factors for violence. These factors include:

1. Mental Disorders and History of Violence

- Mental disorders may increase a client's susceptibility to substance abuse, which in turn may increase his/her potential for violence. Any consumer with a reported history of violence should have a risk assessment, including assessment of their use of controlled substances, completed as part of the referral process.
- A risk assessment (danger to self and others) is part of any overall assessment.
- For clients with co-occurring substance use and mental health disorders, providing integrated treatment substance abuse and mental health treatment will minimize violence risk.

2. Static vs. Dynamic Risk

- Static risk factors include psychopathology, elementary school maladjustment, history of violence, Axis II cluster B personality disorder, young age at first violence incident, and frontal and pre-frontal lobe injury.
- Dynamic risk is defined as variable risks, i.e. changes in mental status that proceed and increase the likelihood of violence. These variables may change spontaneously or through intervention.
- Dynamic risk factors include impulsiveness, anger and/or negative mood, psychosis, antisocial behaviors, substance abuse, poor compliance with treatment or disengagement from services, lack of family/community support, and exposure to individuals who are likely to destabilize the client.

Management of Clients with histories of violence

The identification of static and dynamic risk factors will determine whether FSP programs are safely able to manage a client's care in the community and assist in the development of appropriate care plans based on clinically based intervention strategies, including:

1. Working with clients to identify triggers to violence or self-harm.
2. Developing relapse prevention strategies, Wellness Recovery Action Plans or other self-care/management plans to manage risk.
3. Regular team assessments of client/community vulnerability.
4. Providing or referring clients to anger management classes/groups.
5. If there is an increase in the assessed violence or self-harm, the following actions should be taken:
 - Treatment should be intensified and the clients' environment managed when clients are engaged strongly with the team and have a strong therapeutic relationship.
 - Rapport and involvement with significant others should be the focus for clients with weak relationships with the team or who are disengaging from services.

Guidelines for implementation

1. Training: DMH should provide training opportunities on an on-going basis for FSP programs on successful strategies for assessing, managing and mitigating high-risk violent behavior.
2. Referrals for at-risk clients should be discussed in a clinical case conference format at the Service Area Impact Teams and should include:
 - A review of static and dynamic risk factors, as outlined above.
 - Facts related to the crime(s), if applicable.
 - Information available through collateral sources i.e., family, associates, employers, and the police.
 - In some cases, screening by Navigators may be indicated prior to assignment, including obtaining all available clinical records.
 - Referrals for at-risk clients who are older adults, ages 60 and above, should be discussed with the Older Adult FSP Impact Coordinator who will facilitate a clinical case conference through the OA Centralized Impact Unit, prior to assignment.
3. Prior to deciding whether to accept the referred client, FSP programs should conduct a face to face interview that includes a violence risk assessment as described above, a review of clinical records. The FSP program should carefully consider the location of where these services are provided to ensure safety. If the provider agrees to outreach, engage and enroll a consumer, the client's care coordination plan should reflect the treatment strategies used to minimize violent behavior.
4. For tracking and informational purposes, Service Area District Chiefs should notify the Countywide Age Group District Chief of instances where clinical case conferences result in a decision to not enroll a client into an FSP due to the client's violence potential.