Behavioral Health Crisis Management Guidance

1) For **Providers during office hours**, inform immediately your Behavioral Health Provider for further assistance and evaluation regarding the Behavioral Health Emergency. If not immediately available, then:
    a. Complete Risk Assessment (see "Process for Psychiatric Emergency" guide)
    b. If patient is suicidal, or at other high risk to self/others, determine what further support is needed. Based on your clinical assessment you may opt to complete a Safety Plan with the patient. Refer here for more information on the process for Suicidal Risk Calls.
    c. Help the patient get to Inpatient care or evaluation, if needed:
        i. **Voluntarily**: Direct patient to Inpatient care. Call ahead to admissions to let the facility know the patient is in route. Be sure to follow up and ensure the patient arrived.
        ii. **Involuntary**: Call 911 or Crisis Services:
            1. Spokane Regional Crisis Line: 877-266-1818
            2. Idaho Suicide Prevention Hotline: 208-398-4357
                a. 24-hour access to crisis response services
                b. ITA (involuntary) detention of patients
                c. Immediate assistance to people in emotional crisis
    d. Call 911, if imminent or high risk, such as when the:
        i. Patient attempted suicide
        ii. Patient is threatening suicide now
        iii. Patient is very confused, disoriented, or has slurred speech
        iv. Situation sounds like a life-threatening Emergency to Triage/BHP
        v. Patient is violent or threating to harm self or others. Note, if patient is threatening violence to others, you may have a duty to warn potential victims. Consult with another professional to determine a course of action, if needed, and include the Risk or Legal department to assist.
    e. Call Crime Check (509-456-2233) if a police response is needed but is not required immediately

2) For **Providers on call** (for patients not otherwise captured by the Access Nurse System):
If an on-call provider discovers the patient is **suicidal or deemed to be of imminent danger** to others, please gather the following information:
    a. Current LOCATION of patient (confirm address and phone number, if possible)
    b. Current RISK - Ask the patient if they have a plan to harm themselves, or others
        i. If the patient **indicates intent to harm self/others or have ingested medication**, call 911, and direct emergency services to the patient's current location.
        ii. If the patient is suicidal, but **not determined to be in imminent danger**, the call can be transferred to the 24/7 Regional Crisis Line: 1-877-266-1818.

3) For **severe, adverse reactions to medication**, follow emergency protocol
4) **Reporting suspected** abuse or neglect **of a vulnerable person (child, elder, disabled, etc.)**
5) **Submit a RISQI** and/or reach out to the Risk department though Teams by following the policy.
    a. You can also email CHAS' legal department legal@chas.org as needed for legal questions.
6) **In ALL cases, be sure to thoroughly document** all conversations and actions taken to promote patient safety in the patient's medical record; remember: *"If it's not documented, it didn't happen."*

KVH Ellensburg

SUICIDE PREVENTION SAFETY PROTOCOL

Patient calls or presents to clinic with threats/thoughts of suicide intent or responds positive to question 9 of PHQ-9: "Have you been having thoughts that you would be better off dead or thoughts of hurting yourself in some way?" Staff member notifies primary care provider (PCP), behavioral health care manager (BHCM), or psychiatric consultant (PC) immediately.

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The provider asks the patient if s/he has a suicide plan/administer **COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)**

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If the patient has a **credible plan** or is evasive/not sincere in his/her answer → **See Credible Plan Questions/Risk Stratification**

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If the patient is determined to be at <u>moderate</u> or <u>high</u> risk level

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Tell the patient that you are worried about his/her suicidal thoughts and do not leave patient unattended/alone >5 minutes

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If PCP, BHCM, and/or psychiatric consultant completes a safety plan with patient. → **See Safety Plan**

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If unable to complete safety plan

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Call KITTITAS COUNTY CRISIS Line and notify Designated Crisis Responder (DCR) that you have a patient in crisis (509) 925-9861 (Provide: name, DOB, and indicate safety concerns), if DCR is unavailable--call 911

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A staff member needs to be with the patient at all times while waiting for police/ambulance/family member to transport to ED or Comprehensive for crisis evaluation—enlist help of another staff to look out for first responder. If family is called/arrives, please sit with family in lobby while evaluation plan is finalized. (Over phone: stay on phone until DCR/first responder and/or family make contact with patient)

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Police/ambulance/family arrives and takes the patient to the ED or Crisis for evaluation

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Enter a brief note in Cerner documenting the reason for sending the patient to the ED/Crisis (Comprehensive Ellensburg)

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Plan for follow-up to coordinate care—send a message to Clinic Assist Pool for check in call with patient the following business day—follow up appointment should be made at this time.

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If the patient leaves the clinic against medical advice, call 911 and request welfare check/crisis evaluation—provide dispatcher with description of patient, situation, and—if known--vehicle or which direction they headed if on foot.

National Text Crisis Line: Text "Home" to 741741
National Suicide Prevention Line: 1-800-273-8255

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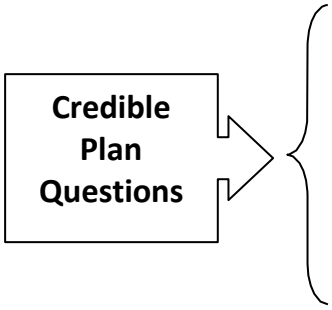
Credible Plan Questions/Risk Stratification

Most individuals who make statements suggestive of suicidal/self-harm ideation should be assessed further by a mental health professional for risk for suicide, psychiatric diagnosis, and appropriate treatment. **The issue is whether the assessment should be performed within the same day or less emergently.**

The evaluation of suicidal risk involves assessing multiple risk factors, including alcohol/drug dependence/abuse, prior suicide attempts, affective disorder, lack of support system, poor physical health, and hopelessness. After someone makes a suicidal statement or statements with clues about possible suicidal thinking, **some of the most useful questions that can be:**



1. **What specific thoughts have you had about harming yourself?**
2. **How seriously are you considering harming yourself?**
3. **Do you have a plan?**
4. **What is your plan?**
5. **Do you have the means to carry out this plan?**
6. **How likely are you to act on the plan?**
7. **Are you likely to act on this or other plan in the next few weeks?**

Other questions that can be helpful to ask in assessing risk

8. **Do you have any hope for yourself?**
9. **Are you using drugs or alcohol to excess now?**
10. **Have you used drugs or alcohol to excess in the past?**
11. **Have you ever tried to kill or harm yourself in the past? If so, when and how?**
12. **Have any family members tried to kill themselves?**
13. **Do you have other people that you are closely connected to? Do you feel supported by these people?**
14. **Have you had serious depressions or other mental health problems in the past?**

Risk factor checklist

Suicide notes ▪ Family problems ▪ Loss of an important person or relationship

- Making final arrangements ▪ Legal problems ▪ Family history of suicide
- Giving away possessions ▪ Poor coping skills ▪ Friend has attempted suicide
- Reading or writing about death ▪ Limited support system ▪ Previous suicide attempts, cutting
- Sad or depressed affect, hopelessness ▪ Increased risk taking ▪ Plan to commit suicide
- Sexual identity issues or sexual abuse ▪ Drug and/or alcohol use ▪ Sense of desperation
- Social withdrawal or isolation ▪ Humiliation or rejection ▪ Access to a means to harm self (firearm)

Risk Level

Low risk: no immediate plan to kill self, few risk factors, good physical health, and identifiable support system

Moderate risk: no immediate plan to kill self but has several risk factors (prior suicide attempts, depressive disorder, substance abuse) or acute physical or psychosocial stressors (e.g., poor health, lack of support system, loss of spouse)

High risk: participant plans to kill self in immediate future, recently attempted suicide with lethal means, and clinician impression of carrying out suicide intent is strong due to one or more high-risk factors (e.g., prior suicide attempts (especially if recent), severe depression, active substance abuse, lack of support system, loss of spouse, feelings of hopelessness, poor health)

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LOW AND MEDIUM RISK ACTION

1. Ensure patient has follow up with either PCP, BHCM, and/or psychiatric consultant within 2 weeks for low risk and within 1 week or less for medium risk—your judgment may dictate that follow up needs to happen even sooner.
2. Always provide the patient with the Kittitas County Crisis Line (509) 674 2881 and National Text Crisis Line 741741, either can be used if suicidal ideation worsens, 911 is also an option for immediate help but will involve police.
3. Utilize behavioral activation: "what is one pleasant thing or an important task that you can do daily until your follow up appointment?" (e.g. "go for a walk with a friend", "feed my horse", "walk to get the mail", etc.)

LOW RISK SITUATION SCRIPT:
I am concerned about you. I understand from what you've told me, that it is unlikely that you would act on the thoughts about suicide you've had. Nonetheless, I think it would be helpful for you to talk to someone. I would like to arrange a follow up with your provider.

MEDIUM RISK SITUATION SCRIPT:
I am concerned about you. I understand from what you've told me that these thoughts of suicide are a problem for you. I would like to arrange an urgent follow up with your provider.

HIGH RISK ACTION

1. Notify team immediately—Identify location of patient if not in clinic
2. May consult with Kittitas County Crisis Line (509) 674-2881
3. Call 911 if immediate concern
4. Immediate referral to emergency department or to Comprehensive for CRISIS evaluation (must be arranged)

HIGH RISK SITUATION SCRIPT:
I am concerned about you. I believe you are at risk for hurting yourself and want to get some additional assistance. I am going to call for help, what is your location?

Lincoln Hospital

CRISIS RESPONSE PROTOCOL

DETERMINE LEVEL OF BEHAVIOR

In all levels, if behavior is threatening, violent or unsafe in any way, call 9-1-1.

LEVEL 1

Change in behavior while in visit: angry, increased anxiety, or agitation.

- Speak with patient confidentially and privately. Express concern. Identify needs and concerns.
- Provide resources and information based on needs. If warranted, refer to BHCM. Set follow-up appointment as needed.

LEVEL 2

Disruptive, inappropriate, unrelated or bizarre comments, defiance, verbal abuse, hostility or withdrawn behavior of increasing concern.

- If possible, speak to patient confidentially and privately. Express concern. If safe, set limits for acceptable behavior in situation
- Involve BHCM if available to assist in de-escalating patient's behavior. If BHCM is not available, involve a manager or a PCP.
- Escort patient to the ER, if behavior persists or ramps up. Call 9-1-1 if patient is resistant and continues to be inappropriate.

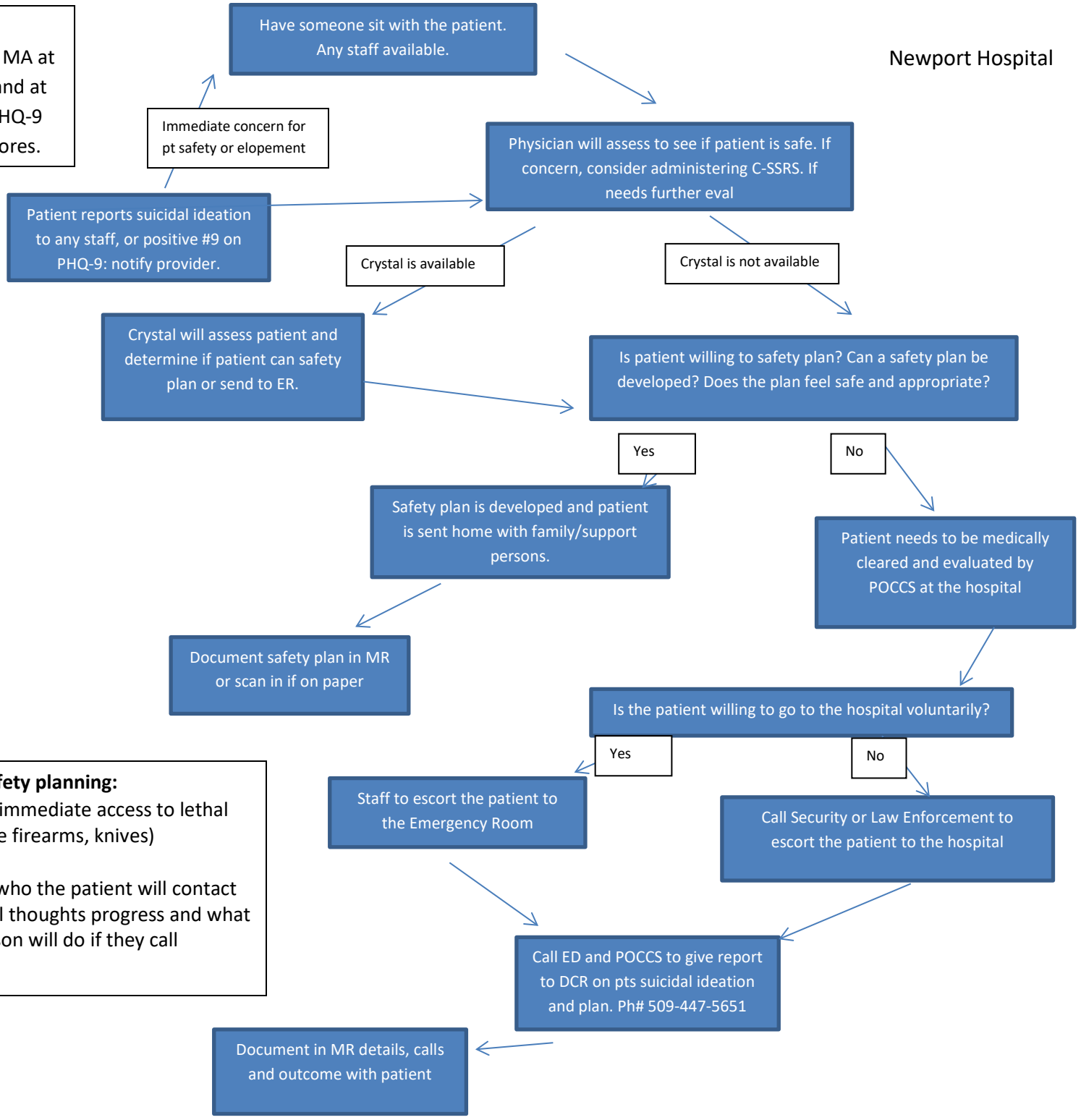
LEVEL 3

Danger to self or others
Violent, aggressive or threatening behavior, escalating threats, agitation, exhibitionism

- Danger to you or others. Physically protect yourself and others if possible.
- Call 9-1-1 immediately. Call Code Gray if patient is violent or threatening violence. If possible, isolate patient in an exam room for safety.
- Danger to self. Suicidal thoughts, threats, ideas, has a plan and access to lethal means
- Escort patient to the ER for evaluation. Call Crisis Response.

Screening protocol:
PHQ-2 and GAD-7 administered by MA at all annual preventive health visits and at least annually chronic pain visits. PHQ-9 administered for positive PHQ-2 scores.

Newport Hospital

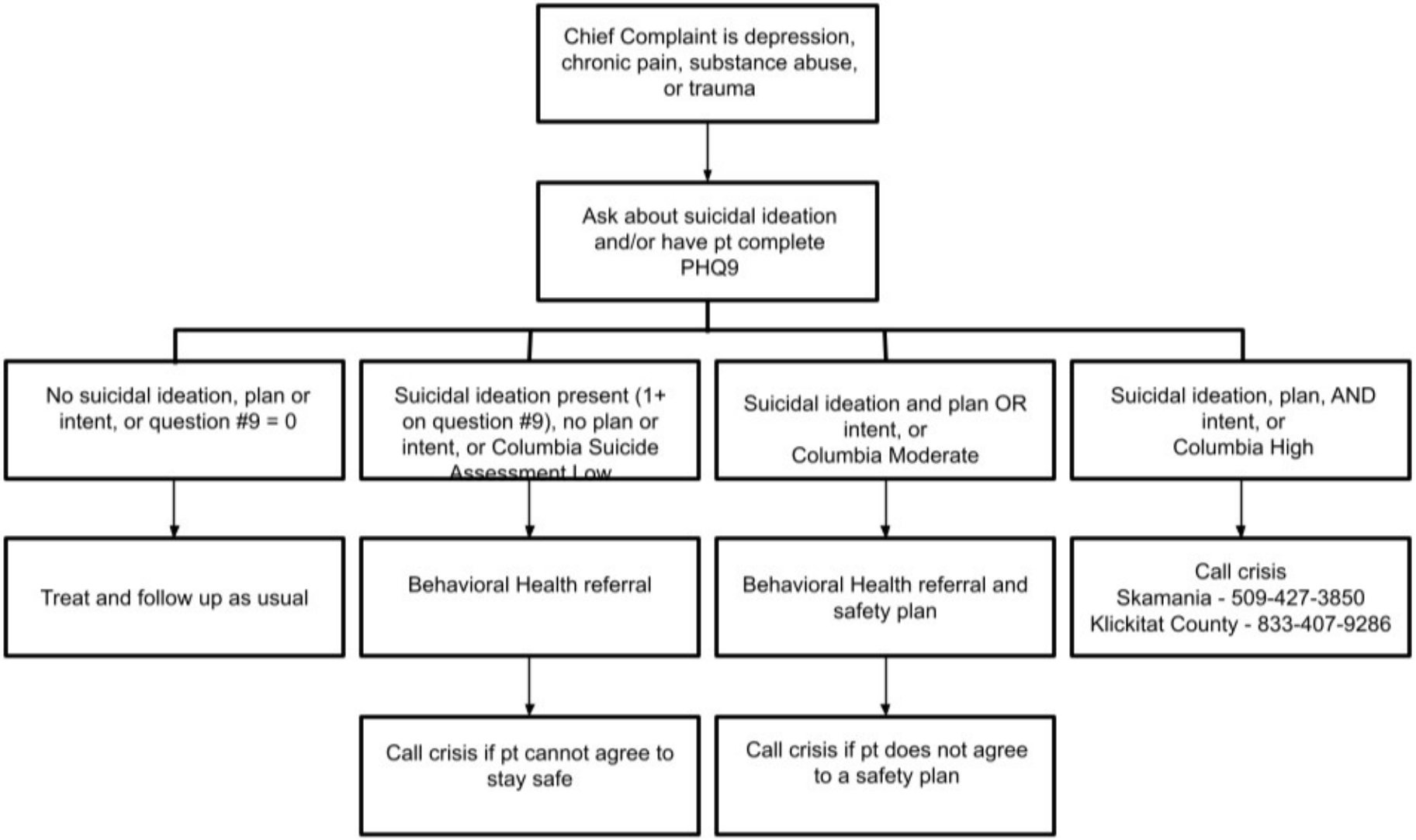


Tips for quick safety planning:

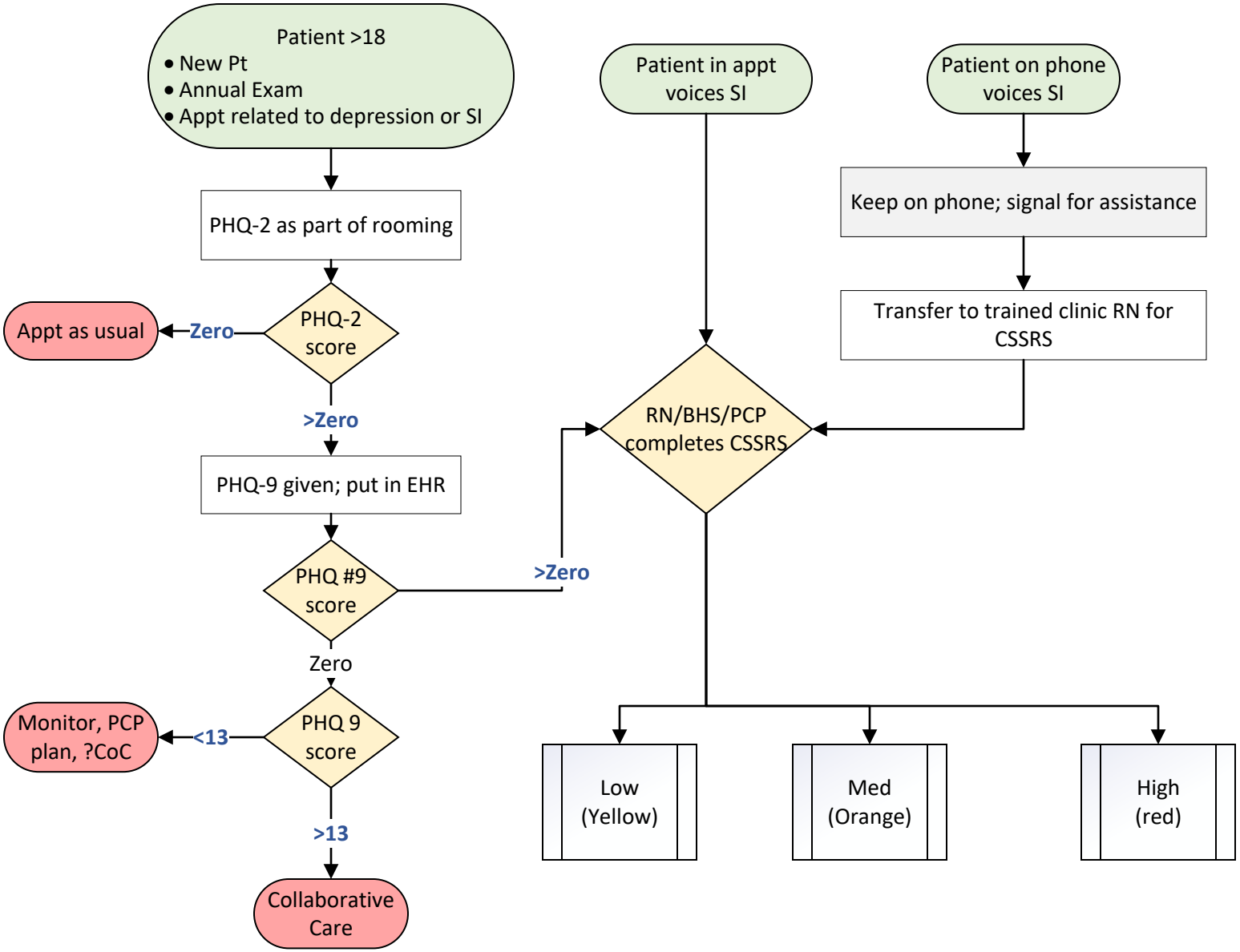
- Remove immediate access to lethal means (ie firearms, knives)
- Identify who the patient will contact if suicidal thoughts progress and what that person will do if they call

NorthShore

Primary Care Suicide Prevention Flowchart



Olympic Medical Center



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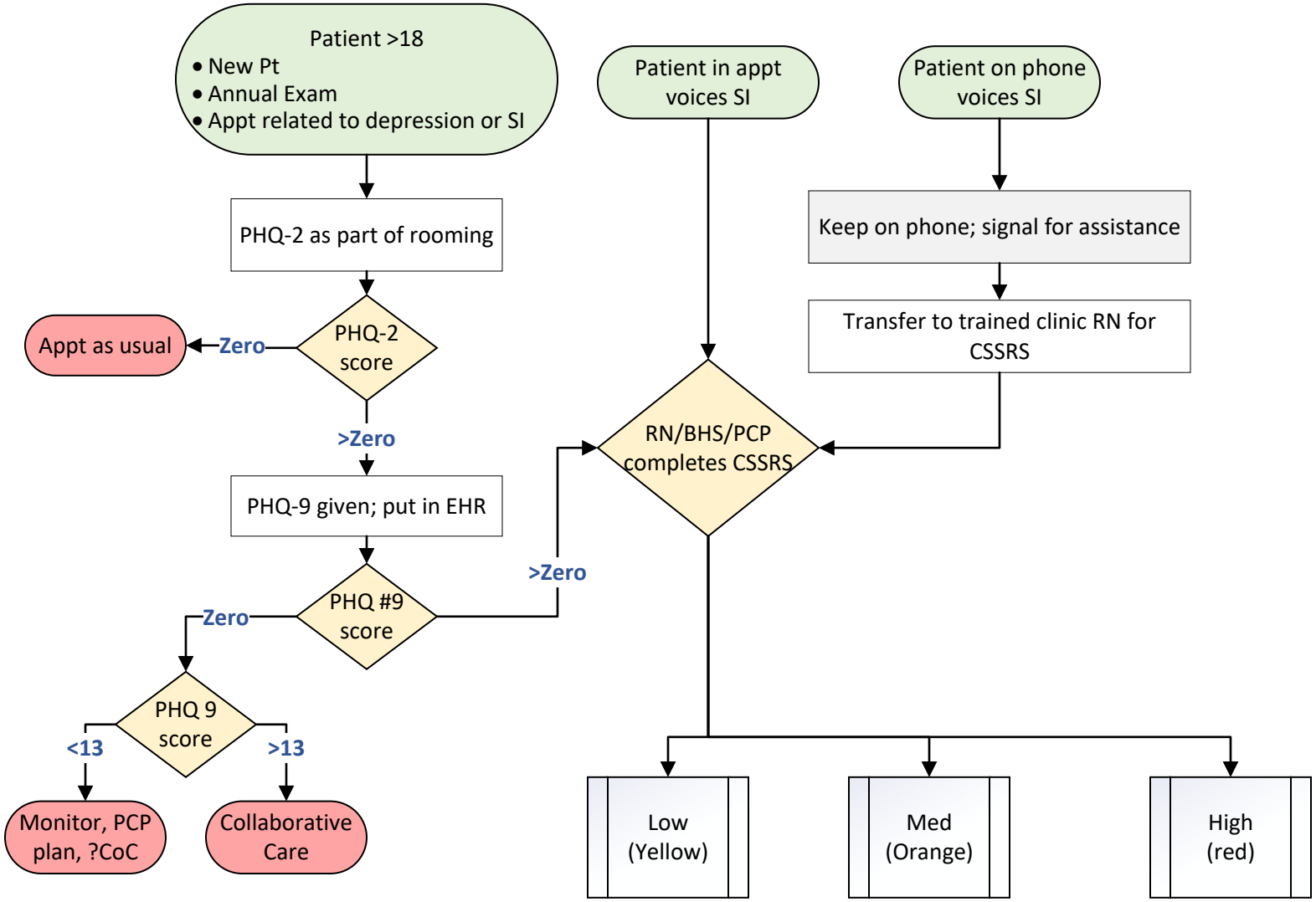

Olympic Medical Center

	In Person	On phone
High Risk: Suicidal Ideation with Plan and Intent	• Alert provider and clinic administration for assistance • Ensure a staff member stays with patient until next level of care • If patient is known to clinic, consult patient's Safety Plan for clinical input (i.e. may have a plan to deal with chronic high suicide risk) **Provider may determine next steps for a known patient with safety plan.** • If willing, have patient escorted (by staff or family) to Emergency Department for evaluation • If patient is not able to safely be escorted to ED, call Volunteers of America (1-800-584-3578), describe the situation, and ask to speak to a Peninsula Behavioral Health Designated Crisis Responder for a pick-up order • When patient is on route to ED, call Emergency Department to give information on patient and to ask ED to call back when patient arrives OR in 30 minutes if patient does not arrive. • Document Risk Assessment and clinical actions in EPIC • Team monitors EPIC for result of episode and acts on needs for coordination of care with PBH or others; if not hospitalized, provides telephone follow-up with patient no later than next business day.	• Keep patient on the phone. If patient hangs up before disposition complete, call 911 for welfare check. • Alert clinic administration for assistance • If patient is known to clinic, consult patient's Safety Plan for clinical input (i.e. may have a plan to deal with chronic high suicide risk) **Provider may determine next steps for a known patient with safety plan.** • Call Volunteers of America (1-800-584-3578), describe the situation, and ask to speak to a Peninsula Behavioral Health Designated Crisis Responder for a pick-up order. • Document Risk Assessment and clinical actions in EPIC • Team monitors EPIC for result of episode and acts on needs for coordination of care with PBH or others; if not hospitalized, provides telephone follow-up with patient no later than next business day.
Moderate Risk: Suicidal Ideation with Plan	• Alert provider of risk result • At provider's clinical discretion, may refer to ED or to PBH Crisis Clinic for additional evaluation • If patient is able to go to PBH Crisis Clinic (open M-F regular business hours) call PBH (360-457-0431) to describe situation and to request a call back when patient arrives OR in 30 minutes if patient does not arrive (if patient does not arrive, call 911 for welfare check) • Consider referral to Collaborative Care Team after crisis is resolved • Document Risk Assessment and clinical actions in EPIC	• Keep patient on the phone. If patient hangs up before disposition complete, call 911 for welfare check. • Alert clinic administration for assistance • If patient is known to clinic, consult patient's Safety Plan for clinical input (i.e. may have a plan to deal with chronic high suicide risk) **Provider may determine next steps for a known patient with safety plan.** • Call Volunteers of America (1-800-584-3578), describe the situation, and transfer to patient for additional assessment. • Document Risk Assessment and clinical actions in EPIC
Low Risk: Suicidal Ideation without plan or intent	• Alert provider of risk result • Provide crisis resources • Provider discusses risk with patient. Consider referral to Collaborative Care Team • Document Risk Assessment and clinical actions in EPIC	• Provide crisis resources • Ensure follow-up is secured before ending call • Document Risk Assessment and clinical actions in EPIC