



Patient and provider safety is important in every primary care clinic. Providers have a duty to protect patients, themselves, their colleagues and potential victims. It is helpful to develop a team protocol for managing psychiatric emergencies such as severe suicidal ideation in the primary care clinic. This example is intended to help primary care clinics develop their own specific protocol(s) for psychiatric emergencies.

Principles:

1. **Know who to call and have the information easily available to everyone in the clinic.** All clinic employees, not just the behavioral health staff or the clinic manager, should have access to this information. Don't wait until you need the information to make sure that you have the phone number for the local crisis line or mental health crisis team easily available.
2. **Don't use Safety Contracts.** Safety contracts have no legal meaning and may give a false sense of security to the clinician. Safety contracts do not reduce the likelihood of suicidal or violent behavior. A contract is not an adequate substitute for a thorough assessment and appropriate intervention. Just because a patient says they will call you before they take action doesn't mean that they will.
3. **Take threats seriously.** Although suicide is a rare event, make sure to assess each patient who is having suicidal thoughts.

Suicidal Patients

Over 30,000 people die by suicide yearly while over 650,000 attempt suicide. Men are more likely to complete suicide while women are more likely to attempt suicide. Risk factors include being male, white, psychiatrically ill, having a substance abuse problem, and being socially isolated. Modifiable risk factors include anxiety and physical pain. The greatest risk factor for suicide is a past attempt with the highest risk coming within a few months after the prior attempt.

Older, divorced or widowed, alcoholic, white males have the highest rates of suicide. The # 1 method of death by suicide involves a firearm. Because of this, reducing access to guns is a major part of suicide risk reduction. Other common causes are asphyxiation and poisoning.

A completed suicide is rare (even in mental health settings) but is a major source of stress and worry for providers. It is also very difficult (at times devastating) for those left behind. This is important to discuss with patients when there is a sense they have talked themselves into the fact that everyone would be better off if they were dead and discuss with them what is concretely keeping them from attempting suicide right now.

A clinic protocol needs to include, at a minimum, the following: 1) a plan for screening those at risk for suicide, 2) education about gathering further information once a patient has screened positive for thoughts of suicide, and 3) a triage plan for determining who needs to be sent to an emergency room immediately versus being followed in outpatient care.



Step 1: Screening

Any patient presenting for evaluation of a psychiatric or substance abuse problem should be screened for thoughts of suicide. This is a standard part of the mental status exam. This can be accomplished using question #9 from the PHQ-9:

“Have you been having thoughts that you would be better off dead or thoughts of hurting yourself in some way?”

Step 2: Gathering Further Information

Any patient who reports thoughts of suicide should be interviewed in more detail regarding the nature of those thoughts, plans that are in place, a history of past self-injury, and the current social environment in which the patient is embroiled. Some questions could include the following:

1. ***Have you already done something to hurt yourself?*** The patient may describe a “dry run” or an attempt that occurred shortly before your evaluation. At this point, the patient should be referred for emergency evaluation.
2. ***Do you have a plan to commit suicide?*** It is appropriate to ask the patient what the plan might be and what effort he or she has gone through to bring about that plan in the future. This involves questions about the means (guns, pills, hanging, carbon monoxide poisoning, others), the potential for rescue if the attempt occurs, and the intent behind the possible attempt (i.e. is there an unambiguous wish to die).
3. ***Have you been struggling against thoughts about hurting yourself or committing suicide?*** Often, patients with major depression have intrusive, unpleasant thoughts about suicide that are frightening to them. This question clarifies the degree to which the patient has been preoccupied with thoughts of suicide.
4. ***Have you attempted to kill yourself in the past?*** Past attempts at self-injury place patients at higher risk for suicide. If a patient answers this question, it is appropriate to ask them what happened and what type of treatment was required (Were they hospitalized medically or psychiatrically?)
5. ***Do you have anything in place (such as family or other social supports) to help keep this from happening?*** A patient with no social supports who has made no efforts for self-protection may be at high risk for suicide.

Step 3: Inpatient or Outpatient Treatment

The final step, once information has been gathered, is to determine if the patient can continue to be treated in the outpatient setting or referred for hospitalization. Some factors useful in guiding this decision:



Outpatient Treatment: A patient who describes no clear plan, no clear wish to be dead, no history of self-injury, and fair social and family supports may be appropriate to manage as an outpatient. Other important clinical factors include the degree to which you know the patient, the ability for close follow-up with the patient, and other comorbid problems (like substance abuse, personality difficulties, and legal problems). One simple rule to go by: if you do not feel comfortable sending the patient home with an outpatient plan, then consult with your team on how to modify the plan.

If the decision is not to send the patient to the ER for possible inpatient admission, it is important to address modifiable risk factors as much as possible. For example, could pain or anxiety be treated right away or are there drug side effects (like akathisia) making it hard for the patient to feel comfortable? While giving hope about the treatment of depression, ask the patient what keeps him or her alive and reinforce those factors as much as possible. If there are any lethal means available, work with the patient (or family) to get rid of those. Close follow up by you or someone else is vital if you have decided on outpatient treatment for a patient with thoughts of suicide.

Inpatient Treatment: A patient with a plan for suicide, persistent thoughts of suicide, and past suicide attempts should be sent to an emergency room for evaluation. In addition, if there is no good follow-up plan and you do not know the patient well, referral for inpatient evaluation should also be made. In fact, if you cannot be convinced that there is a good outpatient alternative for the patient, he or she needs to be evaluated at a local emergency room.

Step 4: Emergency Evaluation: What to Do Next?

If you have decided the patient needs to be in the hospital, the first thing you should do is tell the patient what you think the appropriate thing to do is for his or her safety. This can be a great relief to patients and often they will participate in whatever needs to be done next. That could include:

Direct admission to an inpatient unit: While keeping the patient safe in the clinic, contact the patient's insurance carrier and obtain authorization for a psychiatric admission. Once that is obtained, you call the local inpatient psychiatric unit and obtain a bed for the patient. The patient is then sent to the inpatient unit via ambulance from your clinic. This process may take between two to four hours. As clinic time runs out, this may end up resulting in referral to the emergency room. Refer the patient to the local emergency room. The patient should be safely transported there via ambulance. You place yourself at great risk if you identify patients as being suicidal and needing emergency care but allow them to seek it out or get there on their own. **Finally, please contact that ER and fax them your note.** It is the professional and courteous thing to do. In addition, your note and its history may make the difference between an admission versus inappropriate discharge resulting in an emergent patient call to you the next day or worse, a patient committing suicide.

If you have decided the patient needs emergency referral and he or she refuses care, a referral to the appropriate crisis line or mental health crisis team should be made. In more emergent situations, the police may be called (e.g., the patient tells you he is going home to "blow his brains out" with the gun he just purchased and leaves the clinic abruptly). You and your clinic are not an emergency room and you should not attempt to physically detain someone.





Attempting to predict violence toward others is as difficult as predicting suicide. As with suicide, a past history of violence is a strong risk factor for future violence. Other risk factors include illicit drug and alcohol use (especially current intoxication), a history of criminal behavior, and a history of childhood abuse. In the clinic, you may encounter patients who are menacing, threatening, or overtly violent. You may also encounter patients who make threats about violence toward others in the course of a safe discussion with you and appropriate behavior in the clinic (much like a patient disclosing thoughts of suicide).

Patients who are Overtly Menacing, Threatening, or Violent in Clinic

Every clinic needs a plan for handling patients who present any threat to any provider, staff, or other patient in the clinic. In your clinic, what should a provider do if a patient hits him? What should front desk staff do if one patient threatens and assaults another patient in the waiting room? Who is ultimately in charge and responsible for documenting what occurred and following up with staff about improving future responses? Is there a chart mechanism for noting a patient history of inappropriate behavior in clinic?

This plan for dealing with serious violence and violent threats should include the following:

1. **Response Initiation.** What triggers the response to the threat or act of violence? Is there a panic button or alarm that is accessible in patient care areas? Any staff in the clinic should be able to initiate the response.
2. **Response.** Who will respond once the plan is initiated and who will be in charge? If security is available, they should be the first responders and the job of the clinic staff should be to avoid injury, keep others safe, and call police.
3. **Follow Up. Follow-up with staff is important.** Being threatened or assaulted can make individuals feel very frightened. It is worse when they do not feel supported or believe the clinic leaders are not addressing it or making sure it does not happen again. Legal follow-up will be necessary and difficult decisions regarding care will need to be made (will the patient ever be allowed back in the clinic and if not, where will that person go?).

Different clinicians have different levels of comfort when it comes to de-escalating a potentially violent situation. The safest response is to be clear that the patient is acting inappropriately and ask him to leave. In most situations, security should be contacted so the patient understands that you will neither respond to the threats aggressively nor allow him to continue acting in that way. The end result, at least, is the patient leaving the clinic that day and not returning until he can act appropriately.



Patients Reporting Violent Ideation or Threats of Future Violence

Approaching violent ideation is similar to approaching thoughts of suicide. A clinic protocol should include rules for screening, plans for gathering more information to make a decision about risk and the duty to warn, and a plan for further care.

Step 1: Screening

Asking about violent ideation is a standard part of the mental status exam. It should be asked of all new patients and those who may be at higher risk for violence (the intoxicated, psychotic, or agitated). One question could be:

“Have you been having any thoughts or desires to harm anyone?”

Step 2: Gathering More Information

If a patient reports thoughts of harming others, obtain more information including the presence of a plan, the means to carry out the plan, and a past history of violence toward others. Questions could include:

1. ***Do you have a specific plan to harm someone?***
2. ***Who are you planning to harm? Why?*** It will be vital to know if there is an identifiable victim. A patient who describes a clear and identifiable victim will likely need to be referred for emergency evaluation and authorities should be addressed to discharge the “duty to warn.”
3. ***Have you ever been violent toward someone before?*** This should include questions about arrests for assault, the type of assault (was there a weapon involved), and the role of alcohol or other drugs.

Step 3: Making a Treatment Decision

If the patient’s thoughts of harming someone else are accompanied by a genuine plan and an identifiable victim, you are left with a duty to protect the victim and find some type of treatment for your patient. Treatment planning should ideally involve your team and involve consideration of outpatient or inpatient treatment or emergency evaluation.

The Duty to Warn

Tarasoff vs. The Regents of the University of California is the basis of our duty to warn laws. Tatiana Tarasoff, a young college student at UC Berkeley, was murdered by a male student with a mental illness who had told his therapist he planned to kill Ms. Tarasoff. The therapist had not warned Ms. Tarasoff or her family about this threat (although he had obtained inpatient treatment for the patient).

The law is straightforward. If a patient tells you he or she is going to hurt someone (and that someone is identifiable, not just a vague “somebody”) you have a duty to protect that potential victim. At the point the threat is divulged, privacy laws related to that matter are no longer relevant. As Justice Mathew O. Tobriner stated in the majority opinion of the CA Supreme Court: “the confidential character of patient-psychotherapist communications must yield to the extent that disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.”



There are a number of ways to discharge the duty to warn:

1. Contact the identifiable victim and disclose the threat.
2. Contact the police and disclose the threat (you will be asked the potential victim's name and address as well as that of the patient).
3. Ensure the safety of your patient and the victim through hospitalization of the patient (or in the case of the primary care clinic, emergency evaluation).

Depending on the circumstance, you may have to do one of these or all three. For instance, a patient with psychopathy and a history of violence might be best handled through emergency evaluation, contacting police, and contacting the potential victim. In other instances (such as a patient with schizophrenia with no history of violence who is having command hallucinations to hit his caregiver), the most important step is hospitalization and discussion with the caregiver while contacting police is probably not needed. Consulting with the BHP and/or CP can help a team make the best informed decision.





Example Safety Protocol

This is an example safety protocol that can be adapted to your clinical setting, posted and/or available in print form for staff members to easily access when needed.

A patient threatens suicide



Ask the patient if s/he has a suicide plan



If the patient has a **credible plan** or is evasive in his/her answer



See Credible Plan Questions



Tell the patient that his/her suicidality is taken seriously and that s/he will be sent to the ED for emergent psychiatric evaluation



Notify the charge nurse and have a staff member sit with the patient while ambulance is called



A staff member needs to be with the patient at all times while waiting for the ambulance



Ambulance arrives and takes the patient to the ED



If the patient leaves the clinic against medical advice, call 911



The clinician or the nursing staff calls the ED and notifies the pending arrival of the patient and shares history.



Plan for follow-up to coordinate care



Enter a brief note in EMR documenting the reason for sending the patient to the ED (Do not dictate this note)



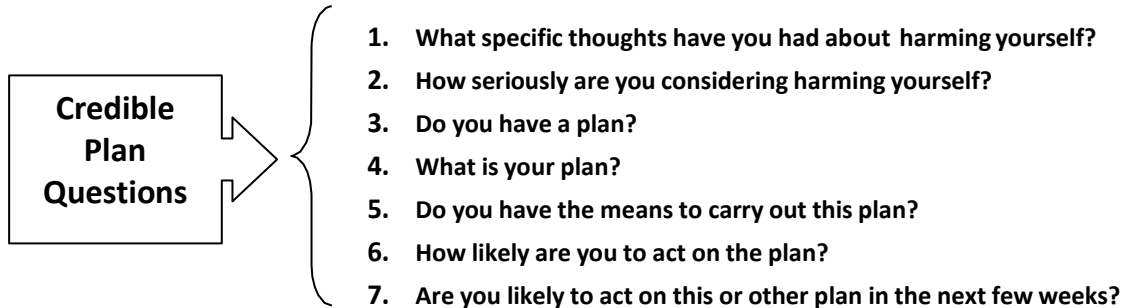
Plan for follow-up to coordinate care





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**



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 Level

Low risk: no immediate plan to kill self, few risk factors, good physical health, 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).





If a patient with safety concerns is not going to be hospitalized, then it is especially important to develop a good safety plan. Consider using national resources such as the safety plan below adapted from The National Suicide Prevention Lifeline: <http://www.suicidepreventionlifeline.org/>

Step 1: What to watch for that a crisis may be developing: (thoughts, images, mood, situation, behavior)

1. _____
2. _____
3. _____

Step 2: Coping strategies – What I can do by myself do to take my mind off my problems (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: Places and community (friend, family, neighbor, a coffee shop, a movie theater, a store) that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____
4. Place _____

Step 4: Who can I ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Providers and resources I can contact during a crisis:

1. Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: How I can make my environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

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