GAU Clinic Protocols for Suicidal and Violent Patients

At the foundation of this discussion is the fact that patient and provider safety is more important than anything else in clinic. As providers, we have a duty to protect the patient, ourselves, our colleagues, and potential victims. Toward that end, there are some basic things to keep in mind:

1. If a patient threatens to harm himself and you are not sure what to do, that patient should be sent to an emergency room for further evaluation. You will never regret making that more conservative choice. If the patient makes vague threats and refuses sound care, the Crisis Line should be contacted and the situation turned over to the County Designated Mental Health Professionals (CD-MHPs).
   a. King County Crisis Line: 866-4CRISIS.
   b. Pierce County Crisis Line: 800-576-7764

2. A “Contract for Safety” (i.e. a promise from a possibly quite depressed and impulsive patient) is neither a contract nor safe. It has no legal meaning and is a minor part of a good suicide risk assessment. This phrase is often charted in lieu of real documentation demonstrating a sound assessment of risk and a well thought out treatment plan. It should not be used.

3. If a patient threatens to harm you or someone in the immediate vicinity, others need to be involved immediately. This means contacting on-site security or the local police using 911 if there is any threat to your safety or that of your colleagues. If there is no immediate risk but the real possibility of future harm to someone, the duty to warn and protect involves an emergency room evaluation, a warning to the identifiable victim, and contacting local law enforcement.

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. Other, and often 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 clients when there is a sense they have talked themselves into the fact that everyone would be better off if they were dead.
A clinic protocol needs to include, at a minimum, the following: a plan for screening those at risk for suicide, education about gathering further information once a patient has screened positive for thoughts of suicide, and 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 or 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 course of care is clear and 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, CO poisoning, among 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 suffering from 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 does he or she need to be referred for hospitalization. Some factors may be useful in guiding decisions:

**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, the outpatient plan is not appropriate. Others may disagree with you but that does not matter when you are making life and death decisions.

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:** 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 can not 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 is the appropriate thing to do for his or her safety. We have found this is often a great relief to patients and they will participate in whatever needs to be done next. That could include:

a. 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 anyway.

b. 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 it 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.

If you have decided the patient needs emergency referral and he or she refuses, a referral to the appropriate CD-MHPs via the county crisis line 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.
Violent or Potentially Violent Patients

Attempting to predict violence toward others is as difficult as predicting suicide. As with suicide, a past history of violence is the best predictor of 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 is a provider to do if a patient hits him? What is the front desk staff to 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:

- **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.
- **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.
- **Follow Up.** The importance of this can not be understated. It is very frightening for staff who have been threatened or assaulted. It is worse when they do not feel supported or that the clinic leaders are not addressing it or making sure it does not happen again. There is also legal follow-up that will be necessary and difficult decisions regarding care (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 all but the simplest of situations, security should be contacted so the patient understands that you will neither respond to the threats aggressively or 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 else?”

**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.

**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 mentally ill male student 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 sociopath with a history of violence might be best handled through emergency evaluation, contacting police, and contacting the potential victim. In other instances (such as with a schizophrenic 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.

**Guidelines for Determining when to Refer to Level 2 Services at the MHC.**

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The guidelines below should be considered just that – guidelines, and not hard and fast rules for delineating between Level I and Level II services. In general, Level I services in the primary care setting should be provided for those individuals who’s needs are less intense and less complicated.

However, as this program is still in its infancy, it is not yet known how many patients will fall into each category, and it is also not yet demonstrated how much of the Care Coordinators’ time will be focused on other duties (besides direct client care) such as coordinating between the primary care physicians and the psychiatrists, or monitoring MHITS to ensure adequate patient follow up. So, with those disclaimers, here are the initial guidelines for determining when to refer to Level 2 services:

1. Patients who have a degree of disability (due to a mental health condition) that would indicate that they are likely to be eligible for GAX funding.
2. Patients who are significantly impacted by a serious and persistent mental illness and who’s symptoms could be treated more effectively in a community mental health setting.
3. Patients who are demonstrating significant suicidal intent and behavior, or self-injurious behavior.
4. Patients who are not improving with Level I, Care Coordinator services, and for whom the medication regime isn’t effective in improving their clinical status.
5. Patients with extraordinary or complex mental health/case management needs (homeless, needing assistance with food, needing advocacy with other external systems, etc) that exceed the capacity of the Level I position.
6. In general, individuals with an Axis II Personality Disorder should be able to be treated successfully in the primary care setting, by the Care Coordinator, consulting psychiatrist, and physician. However, if their degree of behavioral acting out or repeated attempts at suicide or self injurious behavior cannot be managed effectively, or if too much disruption of the primary care setting occurs, then a referral to the community mental health setting should be considered.
7. Any other individual who, in consultation with the consulting psychiatrist, is deemed to be inappropriate for the primary care setting and the lower level of mental health care treatment available in that setting.