Proposed Behavioral Health Crisis Plan
Adapted from the AIMS Center
Rev December 2019

General Principles:

1. A behavioral health crisis might include a patient with high risk for suicide or violence, or any other extreme emotional disturbance causing a person to be agitated and unable to be calmed down. When faced with such a crisis, identify a contact to reach out to and have the information easily **available to everyone in the clinic**. All clinic employees should have access to this information. Each community has access to a local crisis line or mental health crisis team. Don't wait until you need the information to make sure that you have those phone numbers available and posted at your practice. The AHP BHI team AHPBHIT@URMC.Rochester.edu is happy to help you identify the contacts relevant to your practice.

2. Do not use Safety Contracts or "no suicide 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. Do use Safety Plans or "Safety Planning Interventions". A safety plan is a prioritized written list of coping strategies and sources of support to be used by patients who have been assessed to be at high risk for suicide. A safety plan template and a guide on how to complete it are included under this resource section.

4. Take threats seriously. Although suicide is a rare event, make sure to assess each patient who admits to having suicidal thoughts.

Suggested Guidelines for Management of the Patient in Mental Health/Suicidal Crisis

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: Gather additional clinical 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 kill yourself? 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 or killing yourself? 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.

6. What would prevent you from going through with attempting to harm or kill yourself?

Step 3: Risk rating. This is an assessment of the risks and protective factors based on the above information which leads to a clinical rating of low, moderate or high risk in terms of any imminent threat to the patient. Those with moderate or high rating need to have a safe plan in place.

Step 4: Emergency Evaluation (if needed). This is accomplished by calling 911, the mobile crisis team if available and/or your local emergency department.

Suggested Guidelines for Management of the Patient in Mental Health/Violent/Homicidal Crisis

Attempting to predict violence toward others is as difficult as predicting suicide. Rather than predicting suicide or violence, clinicians are better at assessing risk and protective factors. 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).

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 a safe 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.
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.

Legal duty to protect potential victims of violence:
If a patient tells you he or she is going to hurt someone (and that someone is identifiable, not just a vague "somebody") clinicians have a legal duty to protect that potential victim from harm regardless of any confidentiality limitations.

There are a number of ways to discharge this duty. Use your clinical judgement to decide which is most appropriate in each situation:

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 by sending your patient to the ED for further evaluation and possible hospitalization.