HOLLAND HEART THERAPY

# Crisis & Risk Protocol

*What to do when a client presents with elevated risk*

Risk situations are part of clinical work. They are not a sign that you are doing something wrong. The expectation is not that you handle them alone, it is that you respond clinically, follow this protocol, and bring me in. Print this document. Keep it close.

> **Bottom line.** Stabilize the session. Assess clinically. Contact your supervisor before the client leaves. Document thoroughly. We will move through these together.

## Suicidal Ideation

### *Stabilize the session*

Stay present. Slow your pace. Validate the client's experience without minimizing or amplifying. Do not end the session prematurely. Do not promise confidentiality you cannot keep, but also do not over-promise rupture.

### *Assess*

Conduct a clinical risk assessment, including ideation, intent, plan, means, timeframe, prior attempts, current protective factors, and current stressors. Use the Columbia Protocol or another validated screener if helpful. Document your assessment.

### *If risk is moderate to high*

1. Contact me before the client leaves the session.
2. Co-create a safety plan with the client (Stanley-Brown framework or similar).
3. Reduce access to lethal means in collaboration with the client and their support system if possible.
4. Determine the appropriate level of care: continued outpatient with increased frequency, IOP/PHP referral, mobile crisis, voluntary or involuntary hospitalization.
5. Verify the client's location and confirm a support person is available if needed.
6. Document the assessment, the plan, and the rationale before the end of the day.

### *If risk is imminent*

If the client is in immediate danger of acting on suicidal intent:

- Do not leave the client alone in the session, virtual or in-person.
- Contact me immediately. If I am not reachable within reasonable time, contact emergency services (911) or the 988 Suicide & Crisis Lifeline.

- If telehealth, ask the client for their physical address and the name of someone with them. If they are alone and at imminent risk, you may need to authorize a wellness check by local law enforcement.
- Document everything as soon as you are able.

## Self-Harm (without imminent suicidal intent)

- Take the client's report seriously. Do not minimize.
- Assess severity, frequency, function, and access to means.
- Discuss medical care if there is an injury that requires it.
- Develop a plan together for managing urges and reducing access to means.
- Document and bring to next supervision.
- Persistent or escalating self-harm warrants supervisor consultation the same day, even without active suicidality.

## Homicidal Ideation or Threat to Others

Virginia's duty to protect (Code § 54.1-2400.1) applies when a client makes an overt statement of a specific and immediate threat of serious bodily harm against an identifiable person. When you become aware of any threat:

7. Stay calm and continue the clinical conversation.
8. Assess specificity, intent, identified target, access to means, and history of violence.
9. Contact me immediately, before the client leaves the session if at all possible.
10. Together, determine whether the statutory threshold for the duty to protect is met.
11. If the duty is triggered, we will work through warning the potential victim, contacting law enforcement, considering civil commitment, and continuing treatment until the threat reasonably resolves.
12. Document the assessment, the consultation, the actions taken, and the legal reasoning. Be factual and precise.

## Child Abuse or Neglect Disclosure

- Listen. Do not lead the client. Do not interrupt the disclosure to call CPS in the middle of session.
- Once the client has shared what they need to share, communicate clearly that you are required to report what they have told you, and explain what that process looks like.
- Contact me before the client leaves if at all possible. We will discuss the disclosure and how to file.
- File the report with the Virginia DSS CPS Hotline (1-800-552-7096) within 24 hours.
- Document the disclosure factually, the report you made, and the timing.

- Continue treatment with the client. Mandated reporting does not end the therapeutic relationship.

## Adult Abuse, Neglect, or Exploitation

- Same general process as above, with reports going to Adult Protective Services (1-888-832-3858).
- Applies to aged or incapacitated adults.
- If you are uncertain whether the threshold for incapacity is met, consult.

## Intimate Partner Violence

IPV does not always trigger a mandated report, but it always warrants supervisory consultation the same day. The risk profile of clients in IPV situations changes quickly, and safety planning has its own specific structure that differs from standard suicide safety planning. Bring it to supervision.

## Substance Withdrawal or Acute Intoxication

- If a client presents to session intoxicated, the priorities are immediate safety and not making clinical decisions you cannot defend later.
- Do not let an intoxicated client drive.
- If they are alone, contact me to discuss next steps.
- Severe withdrawal from alcohol, benzodiazepines, or opioids can be medically dangerous. Refer to medical care or emergency services as appropriate.

## Dissociation, Acute Trauma Response, or Psychosis

- Stabilize using grounding skills. Slow down. Reduce stimulation.
- Do not push trauma processing in this state.
- Assess for safety to drive or be alone.
- If you suspect new-onset psychosis, contact me. Acute psychosis often warrants medical evaluation.

## After Any Risk Event

- Documentation is completed by end of day.
- A debrief with me happens within 24-48 hours.
- Self-care is not optional after these encounters. Risk work is hard. Tell me what you need.

**The thread.** You are not expected to handle these situations alone. The expectation is that you stabilize the moment, contact me, and document. The clinical decisions are made together.