Rancho Los Amigos National Rehabilitation Center
OUTPATIENT SERVICES: MOBILE CLINIC POLICY AND PROCEDURE

SUBJECT:	**Management of Mental Health Crisis-- Suicidal and Homicidal Ideation in the Field**	**Policy No.:**	**101**
		Supersedes:	**NEW**
		Revision Date:	**February 1, 2022**
		Page:	**1 of 7**

PURPOSE:
To ensure that all Housing for Health (HFH) mobile clinic behavioral health (BH) staff have an established process to respond to patient in mental health crisis expressing suicidal or homicidal ideations, gestures or behaviors in order to prevent risk of patient suicide or mental health crisis.

POLICY:
The HFH Mobile Clinic Team members will improve patient safety and reduce risk of suicidal ideation (SI) and homicidal ideation (HI) by implementing intervention and resources to support the management of a patient in crisis. The goal is to assist staff in identifying patients who demonstrate suicidal ideation or HI or behaviors and to initiate the appropriate intervention.

SCOPE of SERVICE:
The Social Work Supervisor will be responsible for coordinating educational training in suicide risk screening and intervention, for all BH staff within the mobile clinic teams and will maintaining record keeping of all employee training and updates to ensure competency and compliance with mobile health (MH) management protocol.

Definition of Terms:

Suicidal history: Documented or verified history of suicide attempts or gestures

Expressed thoughts of death and dying: patients' expression of a desire for death but there is no expressed statement of acting upon the thought e.g. 'I wish I were dead ', 'I wish they would put me out of misery'

Suicidal Ideation: a patient's expression of desire to take own life but there is no defined statement of will take his or her life own life

Suicidal intent: Patient verbalizes a definite desire /intent/plan /threat to take his/her own life e.g., I am going to kill myself

Suicidal gesture: Any action taken by patient towards self with apparent or expressed intent of bringing about self-injury or death "cutting wrists, stockpiling medications and taking overdose

Lethality: Extent to which patient has the capability and intent to cause own death, e.g. (the patient has a higher lethality based on how easily death can be accomplished via the gesture) … loaded gun has higher lethality than 100 aspirin tablets

PROCEDURE:

The following shall provide guidance on identifying risk factors, interventions to occur for high-risk patients, and appropriate documentation to ensure the safety of our patients.

1. Upon routine referral, each BH staff will complete full assessment of patients that will include MH assessment that will help to proactively identify potential or current risk for SI/HI or other MH issues.
2. If upon initial screening there are low or mild SI/HI and/or any other MH issues are identified, consultation and review with Sr CSW should occur to determine if a referral is indicated.
    A. Based on review and consultation with BH team member, if Sr CSW determines he/she will take referral and continue to follow patient and complete a comprehensive assessment to further identify risk and needs and plan
    B. For ex, if patient is reporting depression or distress, but does not appear to be at risk, then a referral should be made to the Sr CSW, if not already involved.
3. However, when there is an elevated risk identified based on initial or any follow up assessments, or at any time there is patient's verbalization and behaviors, the patient is reporting suicidal or homicidal ideation and/or endorses thoughts of wanting to die or harm self or others, the BH team member will immediately a complete risk stratification and follow on-site staff safety guidelines for engaging SI and HI patients and SI protocol (appendix A and B)
4. This guides and protocol will help determine level of immediate intervention.
    A. A follow up referral to CSW should also occur for any patient exhibiting elevated risk.
5. Staff should follow steps and guidance as outlined in the on-site staff safety guidelines and SI protocol.
6. Stratification of risk for SI and HI could be as follows.
    A. None to minimal risk- If minimal risk identified, patient is reporting depression or distress, but does not appear to be at risk; should consult with CSW. Provide mental resources information etc.
    B. Mild to low risk- Patient has SI but no plan or intent to harm self or others, or patient has thoughts of harming others, with no specific target, plan, or access to lethal means. Referral to CSW for follow up. Contract for safety; provide resources.
    C. Moderate to Acute/Severe or immediate risk of harming self- the patient is reporting suicidal ideation and/or endorses thoughts of wanting to die or harm self, has plan or intent, or Patient has HI, a plan to harm someone else, access to lethal means, history of violence, impulsivity, overt symptoms of distress, etc.
        1. Staff should follow on site safety guidelines for HI, SI, and SI protocol (appendix A & B).
        2. These guidelines include immediate notification of law enforcement, PMRT, or onsite psychiatry (if available). As well as immediate notification to Sr CSW or SW, sup. Sr CSW should respond onsite or provide consultation via phone, if available.
        3. Remain with the Patient and Behavioral Health Support until Law enforcement or PMRT arrives, conducts their evaluation and if placed on a 5150, until a hospital bed is confirmed, and the patient is transported to the hospital.
        4. If clinically appropriate and/or indicated, when possible, follow up with patient following psychiatric hospitalization with a face-to-face visit or phone call

reinforcing therapeutic relationship and recovery partnership should occur. When possible, mobile clinic staff should coordinate follow up with any other outreach or treatment team-serving patient.

5. For patients who do not meet 5150 criteria, in collaboration with current outreach/treatment team and under the direction of Sr. CSW or Social Work supervisor, BH team member ensures linkage with mental health and urgent care resources should symptoms worsen, including providing the DMH ACCESS hotline. BH team member should consult and consider referral to psychiatrist for follow up after the crisis intervention.

7. Other than none to minimal risk, all other stratifications of risk require the BH staff member to make a referral to CSW and notification to primary MD should occur for continued follow up.
8. Sr CSW will escalate to Social Supervisor when needed for additional guidance and support.
9. Sr. CSW will refer to mobile clinic psychiatry for evaluation and following per psychiatry referral guidelines.
10. Environmental Assessment should occur with any elevated risk to include physical inspection of surroundings area to identify ligature risk and other potential hazards
11. Documentation in Orchid should occur covering the discussion of concerns and outcome of interventions
    A. BH staff member should document steps taken to provide intervention
    B. Documentation of resources provided including patient education on depression, anxiety, suicidality if appropriate. Document referral to psychiatry or social work.
12. If no risk for SI or HI is identified during encounter but patient is exhibiting other MH crisis such as panic attack, psychosis; BH member should follow protocol on “Guidance for Mental Health issues: What staff should do when encountering MH issues in the field “(appendix C). The BH member should also follow appropriate de-escalation protocols as needed as well.
13. Event Reporting
    A. The Mobile Clinic Physician or designee will reference Rancho Los Amigos National Rehabilitation Center’s ***Policy B704 Event Reporting*** and subsequent reporting requirements in reporting adverse clinical or operational events
14. Crisis Intervention Internal Debriefing
    A. Under the direction of the Senior Clinical Social Worker or designee, the Mobile Clinic team will huddle following a significant crisis intervention event to review the incident, conduct a team well-being check, and evaluate intervention effectiveness and areas to strengthen.

Appendix A: On site staff Safety Guide for engagement with SI patient in field
Appendix B: On site staff Safety Guide for engagement with HI patients in field

Appendix A: Onsite Safety Guide for Engagement with Suicidal (SI) Patients:

Purpose: This guide is designed to aid mobile clinic staff members with Crisis Intervention options for providing services to patients expressing suicidal ideations. This guide is intended to be used in conjunction with an existing policy.

Please note staff are expected to notify all patients of their mandated reporting responsibility and for or all cases involving safety concerns, consultation with the primary care provider and/or immediate supervisor should be held.

In the absence of a medical emergency, and during the course of engagement and a patient endorse suicidal ideations, have already taken steps toward ending their life, and implement the following steps. If **No** SI, but mild depression and anxiety, with patient's consent provide a warm handoff to clinic's Clinical Social Worker (CSW).

Step 1: Remain calm, to complete the suicide risk assessment. Questions may include:

- ***Have you had actual thoughts of killing yourself?***
- ***Any history of suicidal behavior or attempts?***
- ***Have you been thinking about how you might do this?***
- ***Have you had these thoughts and had some intention of acting on them?***
- ***Have you started to work out or worked out the details of how to kill yourself and do you plan to carry out the plan?***
- ****Have you already done anything to harm yourself:*** **If the patient indicates that they have already injured himself, herself, or attempted suicide, or will do so within hours, connect directly with 911, explain situation, conference the call and stay on the line until paramedic/police response arrives.**

Step 2. "Yes" to any of the questions in step 1, staff should proceed with the following steps based on level of risk:

- Acute/Moderate Risk: Patient has a plan, access to lethal means, recent cutting/self-injurious behavior impulsivity, overt symptoms of distress, past attempts etc. (**If time permits and there is no immediate danger always consult with Supervisor or Sr. CSW first)*
- Stay with patient as long as it is safe to do so.
- Contact 911 or Law enforcement (or designated mobile clinic LPS Sr. CSW or Psychiatrist, if onsite and available) for assistance with mental health crisis.
- Notify Sr CSW and or Social Work supervisor ASAP
- Remain with the Patient until Law enforcement, PMRT, or behavioral support arrives, conducts their evaluation as per Management of MH crisis policy. Alternatively, consult with you supervisor on when it is OK to leave the area.

- Mild/Low Risk: Patient has suicidal thoughts, but no identified plan, no access to lethal mean, no self-injurious behavior, etc. Options include but are not limited to.
  - Alert Sr. CSW and clinical staff for consultation
  - Always provide supervision of patient.

Continue: Appendix A: Onsite Safety Guide for Engagement with Suicidal (SI) Patients:

- If the patient lacks coping skills and/or a support system to help mitigate risk and there is no immediate danger (i.e. patient is not Acute risk), the Sr. CSW may initiate referral to psychiatry or PMRT to initiate psychiatric evaluation may be needed.
- Contract for safety and provide resources, and coordinate any immediate community mental health referrals as needed
- Referral to CSW should be made for follow up with patients consent and Sr CSW will provide continued following and coordination of mental health services through DMH as needed.

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Step 3. If a suicidal patient elopes from the location to avoid psychiatric evaluation:

- Notify local Law Enforcement on the nature of the safety concerns.
- Request a welfare check/psychiatric evaluation where patient resides or known address.
- Provide any pertinent information related to patient's threat.

Final step:

- In addition to the crisis intervention, patients with suicidal ideations, or intense feelings of hopelessness should always be provided the suicide prevention hotline numbers as a safety precaution.
- Document in ORCHID nature of incident and disposition.
- Provide follow-up with patient or family to provide support and care coordination.
    - For patients under the age of 13 obtain parent/guardian consent (verbal or written) for BHI referral and document consent according to Rancho policy. (Rancho Administrative Policy no. B504.2 "Authorization by Non-Parent to treat Minors" and Rancho Administrative Policy no. B504.3 "Medical Consent for Minors")

Emergency Contact:

- 911, For Mental Health Crisis Assistance
- DMH ACCESS/PMRT (1800) 854-7771
- Suicide Prevention Center 1-877-727-4747, and
- National Suicide Prevention Lifeline 1-800-273- 8255

Appendix B: Onsite Safety for Engagement with Homicidal (HI) Patients

Purpose: This guide is designed to aid mobile clinic staff members with Crisis Intervention options for providing services to patients endorsing homicidal ideations. This guide is intended to be used in conjunction with an existing policy

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Please note staff are expected to notify all patients of their mandated reporting responsibility and for or all cases involving safety concerns, consultation with their supervisor or clinical staff should be held.

In the absence of a medical emergency, and during engagement and if a patient endorse homicidal ideations, implement the following steps. If **No** "HI continue with patient care and needs assessment as necessary. Consider consultation with Sr CSW if other issues or concerns present or more support needed. For suicidal ideations, refer to facilities policy/ procedure.

Step 1: Remain calm and complete a risk evaluation. Questions may include:

- Do you have current or past thoughts of hurting someone?
- Do you have a specific target in mind and if so, who is the specific target, specific target contact information and location?
- Have you had these thoughts and any intentions of acting on them?
- Have you started to work out or worked out the details of how you plan to carry out this thought?
- *Do you have access to guns/weapons/lethal means?

Step 2. If "Yes" to any of the questions in step 1, staff should proceed with the following steps based on level of risk:

- Acute/Moderate Risk: Patient has a plan, access to lethal means, history of violence, impulsivity, overt symptoms of distress, etc.
  - Alert clinical staff, including Sr CSW for guidance on next steps
  - Always provide supervision and stay with patient if possible.
  - Contact 911 or Sheriffs for assistance with mental health crisis.
  - Obtain as much information as possible on specific target and share with law enforcement with intention to notify and warn.
  - Refer to Sr. CSW for follow and provide support and care coordination
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- Mild Risk: Patient has thoughts of harming others, no specific target, plan, or access to lethal means, etc. options include but are not limited to,
  - Alert Sr. CSW and clinical staff for consultation
  - Always provide supervision of patient.
  - After consultation with Sr CSW or Social work supervisor, contact the department of mental health Access/PMRT (Psychiatric Mobile Response Team), to initiate a psychiatric evaluation on patient's behalf, if appropriate
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Continue: Appendix B: Onsite Safety for Engagement with Homicidal (HI) Patients

- Referral to CSW may also be made for follow up and coordination of mental health services through DMH.

- BH staff should provide any immediate resources and referrals through DMH or other support services as needed.

Step 3. If a homicidal patient elopes from the location to avoid psychiatric evaluation:

- Notify local Law Enforcement on the nature of the safety threat.
- Provide as much information as possible on specific target and share with law enforcement with the intention to notify and warn
- Request a welfare check/psychiatric evaluation where patient and if appropriate target resides or known location.
- Provide pertinent information related to patient's threat.

Final step:

- Based on your reporting duty (if provide with the information) notify the intended target/victim of the threat, and Law Enforcement where the intended victim resides. Please consult with immediate supervisor if unsure of reporting obligations (Law).
- Document in ORCHID nature of incident and disposition.
- For patients under the age of 13 obtain parent/guardian consent (verbal or written) for BHI referral and document consent according to Rancho's policy. (Rancho Administrative Policy no. B504.2 "Authorization by Non-Parent to treat Minors" and Rancho Administrative Policy no. B504.3 "Medical Consent for Minors")

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