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

SUBJECT:	**Housing for Health Mobile Clinics Suicide Risk Assessment Policy**	**Policy No.:**	**101.1**
		Supersedes:	**New**
		Revision Date:	**February 3, 2022**
		Page:	**1 of 6**

PURPOSE

The mobile clinic is committed to providing quality and safe care for those patients identified as high risk for suicide. The purpose of this policy is to create an effective, multidisciplinary approach to proactively screen and respond to patient with expressed suicide ideations, gestures, or behaviors in order to reduce the risk of patient suicide.

POLICY:
This policy is to promote a therapeutic environment that is safe as reasonable possible for those patients who present a potential for suicide or intentional self-injury. The goal is to assist staff in identifying patients who demonstrate suicide ideation or behavior and to initiate the appropriate intervention.

SCOPE OF SERVICE:
Each clinical discipline or service will be responsible for coordination educational training in suicide risk screening for all staff within the clinic teams and will maintain record keeping of all employee training and updates to ensure competency and compliance in suicide risk screening.

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

1. **Screening:** A suicide risk screening will be administered on all mobile clinic patients being seen by mobile clinic medical team

a. Upon initial visit with primary care provider all patients on will receive depression/suicide screening (PHQ2 and PHQ9) with initial screening administered by Nursing
b. Questionnaire / Screening tool is administered by nursing in the electronic Health record
c. The screening will be done annually thereafter the initial visit, unless there is an identified change in risk of suicide or patient shows signs of at-risk behavior that warrants a new screening to occur (i.e., significant change in condition, new diagnosis, verbalization of suicidal ideation) (see appendix B for Common Risk Factors for high-risk suicide)
d. Whenever there is an elevated risk, based on screening or on patient verbalization or behavior, the PHQ2 should be completed before annually due. For ex, patient stating I do not want to live or recent suicide attempt, or patient reports traumatic events

2. **Intervention**: appropriate measures will be taken to ensure the safety of patients identified at high risk for suicide via screening
    a. Based upon the assessment and as indicated by the Suicide Risk Screening tool (PHQ2) if the patient is reporting depression distress, but does not appear to be at risk, a consult and review with Sr. CSW should occur to determine if referral is indicated
    b. Based on review, the Sr CSW will determine if he/she will take referral and will follow up with patient and complete a comprehensive assessment to further identify risk.
    c. Nursing staff should also provide low risk patient with resource list including mental health resources information and crisis line information
    d. If patient has elevated or high risk, is reporting suicidal ideations, and or endorses thoughts of wanting to die or harm self on depression screening (PHQ2 or PHQ9), nursing should refer to social work and/or psychiatry for further screening.
        i. Staff member should attempt to stay with patient and encourage patient stay to discuss situation with mental health professional
        ii. If psychiatry or social work not available, the staff should complete risk stratification and follow on-site staff safety guidelines for engaging SI and HI patients (appendix A-1)

3. 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 social work or psychiatry. Provide mental resources information, if appropriate.
    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, 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 Staff should complete on-site. Staff should follow on-site staff safety guidelines for engaging SI patients (appendix A-1)
        i. These guidelines include immediate notification of law enforcement, PMRT, or onsite psychiatry (if available). As well as immediate notification to Sr CSW, Psychiatry, or SW sup. Sr CSW should respond onsite or provide consultation via phone, if available.

4. Any staff member who first notices patient exhibiting suicidal behavior and/or comments is to have another employee notify the physician and /or nurse. Staff should try to stay with patient while MD, RN or BH staff arrive.
5. For any patients with acute or immediate risk, staff should follow guidelines in Appendix A-1 for immediate steps to take to help ensure safety of the patient.
6. All documentation should include when the person had the thoughts ideation or intent (e.g., whether current at the time of examination, weeks ago, months ago etc.)
    a. Document discussion of concern with provider or BH team
    b. Document any steps taken to provide intervention (provide resources, referral to social work or psychiatrist)
    c. Document what resources were provided (i.e., patient education information on depression, anxiety, suicidality)
7. Environmental Assessment should occur with any elevated risk to include physical inspection of surroundings area to identify ligature risk and other potential hazards
8. 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
9. 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-1: On site staff Safety Guide for engagement with SI patient in field
Appendix B: Common Risk Factors for Individuals at high risk for Suicide

Appendix A-1: 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, 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 themselves 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
- IF CSW or psychiatry is not available, consult with your supervisor. Try to remain with the Patient until Law enforcement, PMRT, or behavioral support arrives, conducts their evaluation as per Management of MH crisis policy. 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
  - 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), refer to Sr. CSW.

- Provide resources, if needed consult with social work for coordination of any immediate community mental health referrals.
- Referral to CSW should be made for follow up with patients consent to provide continued following and coordination of mental health services through DMH as needed.

.

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 Los Amigos Consent to Treat Minor Policy #504.2

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

Common Risk Factors for Individual at High-Risk for Suicide

Risk Factors: The following risk factors that may elevate a patient's risk for suicide:

- Recent life events for example
  - Death of family member
  - Illness
  - Divorce
  - Auditory hallucinations that command patient to harm self
- Current or recent suicidal ideation
- Suicide plan formulation
- Suicide means
- Suicide ability
- Current or recent suicidal behavior/self-harming behavior
  - When
  - How many attempts
  - Method
  - Previous or present mental illness
- Change in mood or energy level
- History of alcohol or substance use
- Behaviors that require use of restraints (if applicable)
- Patient's personal belonging for presence of potentially harmful objects
- History of Substance Abuse