7.2.35 MENTAL HEALTH DIVERSION – SUICIDE PREVENTION / ADVERSE EVENTS

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References: Penal Code (PC) section 1001.36 and Welfare and Institutions Code (WIC) 4361

Policy Owner: Behavioral Health Division, Acute & Forensic Services Section Manager

Director Signature: **Signature on File**

I. Policy Statement

The California Department of State Hospitals (DSH) requires clear guidelines and procedures for the operation of the Felony Mental Health Diversion (MHD) Program. This policy was created so that the Sonoma County Behavioral Health (SCBH) Felony MHD team can demonstrate compliance with Penal Code (PC) section 1001.36 and Welfare and Institutions Code (WIC) 4361 and serve as a reference for staff.

II. Scope

This policy applies to all Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) staff assigned to provide Specialty Mental Health Services (SMHS) in the Felony MHD Program.

A. To reduce the incidence of suicidal ideation, suicide attempts, and deaths among members enrolled in the MHD Program.

B. To establish consistent standards, roles, responsibilities, and coordinated responses across the system (providers, care managers, crisis services).

C. To ensure compliance with state and federal requirements, best practices, and ethical standards.

III. Definitions

A. Adverse Incidents: An unfavorable medical or psychological outcome, such as suicide, assault, medication error, injury, or death, that occurs during, or is associated with, a patient's contact with healthcare services, and is not due to their underlying mental health condition.

B. Columbia-Suicide Severity Rating Scale (C-SSRS): Is a simple and widely used suicide risk assessment tool. It helps identify if someone is at risk for suicide, assesses the severity and urgency of that risk, and guides the level of support needed. It consists of a series of plain-language questions that can be asked by anyone, including healthcare professionals, teachers, and family members. Questions cover two main areas: **Suicidal ideation:** Asking whether and when a person has had thoughts of suicide. **Suicidal behavior:** Evaluating whether a person has taken action to prepare for or attempt suicide.

C. Department of Health Services- Behavioral Health Division (DHS-BHD): The Sonoma County entity responsible for administering publicly funded behavioral health services.

D. Felony Mental Health Diversion (MHD) Program: DHS-BHD operates a Specialty Mental Health Services (SMHS) outpatient treatment program for individuals participating in MHD Court. The Program provides SMHS using the Assertive Community Treatment (ACT) model of care.

E. Incompetent to Stand Trial (IST): A legal term that denotes a defendant's lack of capacity to participate in legal proceedings or assist in their own legal defense.

F. Mental Health Diversion (MHD): Pursuant to Penal Code (PC) section 1001.36 and Welfare and Institutions Code (WIC) 4361, allows Felony IST defendants to participate in intensive community mental health treatment in lieu of inpatient DSH competency restoration treatment.

G. Mobile Crisis Services Benefit (MCS): The MCS Benefit provides rapid response, individual assessment, and community-based stabilization to Medi-Cal members experiencing a behavioral health crisis. MCS are designed to provide relief to members experiencing a behavioral health crisis, including, through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. While MCS are intended to support an integrated approach to responding to both mental health and substance use-related crises, and the mobile crisis teams will be carrying, trained, and able to administer naloxone, this benefit is not intended to replace emergency medical services for medical emergencies.

H. Pronoun Usage: Throughout this policy, the singular "they/their" is used as a gender-neutral pronoun to promote clarity, readability, and inclusivity.

IV. Policy

This policy is to ensure all program staff assigned to the DHS-BHD MHD Program adhere to the requirements set forth by DSH under Penal Code (PC) section 1001.36 and Welfare and Institutions Code (WIC) 4361. This policy includes procedural guidelines for suicide prevention and review of adverse incident events for clients in the MHD Program.

V. Procedures

General Guidelines

I. Crisis Intervention & Response

1. DHS-BHD has a number of crisis intervention and response strategies, and programs aimed at reducing the incidence of suicidal ideation, attempts, and deaths among members enrolled in the MHD Program and the broader community.

    a. Utilize **988 Suicide & Crisis Lifeline**, which is actively integrated into Sonoma County's crisis system.

    b. National Alliance on Mental Illness (NAMI) - **Warm Line**: 1 (866) 960-6264.

    c. **Mobile Crisis Services**: Sonoma County provides mobile crisis assessments and triage throughout the county, regardless of insurance status. 1 (800) 746 - 8181.

    d. **Crisis Stabilization Unit (CSU)**: Short-term stabilization (up to 23 hours) facility (though currently with limited operations).

    e. **Crisis Residential Services**: Alternative to hospital inpatient care for Medi-Cal members when appropriate.

    f. **Crestwood Healing Center - Psychiatric Health Facility** (PHF): For more acute, inpatient treatment for Medi-Cal members.

    g. **Hospital Liaison Team**: When members are hospitalized, a liaison ensures coordination and continuity of mental health care upon discharge.

    h. **Behavioral Health Bridge House** (BHBH at Arrowood): Available for unsheltered Medi-Cal members with severe mental illness and co-occurring disorders who are stepping down from recent psychiatric hospitalization.

i. **Warm Handoff**: For clients receiving SMHS, a warm handoff refers to the process of smoothly transitioning a patient's care from one provider to another while ensuring that important information is communicated effectively. Providing additional assistance in connecting clients with a new treatment provider during care transitions is considered to be the best practice. This approach helps clients continue vital treatment services, which are instrumental to their recovery. Warm handoff assistance may include:

(1) Identifying the first appointment.

(2) Conducting telephone consultations.

(3) Providing transportation to the first appointment.

(4) Introducing the client to the new care team.

(5) Facilitating clinical consultation with the new care team.

(6) Coordinating ongoing care.

J. Risk Screening & Identification

1. MHD Program staff will screen each client upon admission for suicide risk using the Columbia-Suicide Severity Rating Scale (C-SSRS).

2. While in treatment, DHS-BHD staff assigned to the MHD Program will also screen for suicide risk when additional risk factors are present. These additional risk factors include, but are not limited to, the following:

a. Major life transitions.

b. Personal crisis.

c. Hospital discharge.

d. Death of a family member.

e. A client score of 2 or 3 on the California Integrated Practice, Child and Adolescent Needs and Strengths (CANS) / Standard Adult Needs and Strengths Assessment (ANSA) Comprehensive 3.0 under the "Suicide Risk" item at time of assessment.

f. Client is displaying verbal or behavioral indicators of suicide risk.

g. Client is a potential danger to self, and/or engaging in behavior that could lead to completed suicide based on self-report or collateral information.

3. In the event of a positive screen for suicide risk, any unlicensed staff person in the MHD Program who is conducting this initial screening will consult with a licensed clinician so that further assessment can be completed.

K. Suicide Risk Assessment

1. MHD Program staff who hold a clinical license will conduct the suicide risk assessment by using:

    a. The C-SSRS Adult Assessment and adhere to DHS-BHD Columbia-Suicide Risk Assessment Procedure. Licensed MHD Program staff will use the C-SSRS and assess for:

        i. Suicidal Ideation.

        ii. Intent.

        iii. Plan.

        iv. Means.

        v. Safety environment.

        vi. Comorbid conditions.

        vii. Recent stressors.

        viii. Protective factors.

        ix. History including behaviors.

    b. Scoring and risk level assignment

        i. MHD Program staff will complete the C-SSRS Adult Assessment and assign an appropriate risk level of any of the following and by using relevant scoring material for C-SSRS.

            (1) Low.

            (2) Moderate.

            (3) High.

            (4) Imminent.

    c. Documentation

        i. MHD Program staff will clearly document the rationale for the score given, using clinical training and judgement.

ii. Documentation will be entered into SmartCare, client's electronic medical record.

L. Safety Planning & Interventions

1. MHD Program staff will adhere to the policies and procedures of the DHS-BHD, Policy No. 7.1.27, *5150 Involuntary Detention for Individuals with Mental Health Disorders*, when clinically appropriate to authorize an involuntary hold.

2. MHD Program staff will complete a Safety plan using the available form in SmartCare, and during the following circumstances:

   a. After completion of a C-SSRS Adult Assessment with the results indicating high risk and the client is not hospitalized.

   b. At the clinical discretion of the licensed staff person for low to moderate risks, upon completion of a C-SSRS Adult Assessment.

   c. Within 7 business days after a client is discharged from a CSU or psychiatric hospitalization, immediately following an admission due to suicidal ideation or behavior.

   d. If the client is not hospitalized and has identified a support person (family members, friend, or helper) to participate in safety support planning.

      i. Including support persons on the Safety plan is optional for adult clients.

      ii. If the Safety plan is completed in a face-to-face interaction, request that the client sign a Release of Information form, prior to discussing the plan with the support person.

3. MHD Program staff will complete the following core components of a Safety plan by helping the client to identify:

   a. Feelings and or cues when things in life are going well.

   b. Personal warning signs of overwhelm or crisis.

   c. Coping skills to use in moments of overwhelm or crisis.

   d. Ways to support oneself through engaging in healthy strategies or activities.

   e. People or social settings that can provide additional support.

f. Connections with professionals or agencies that can be contacted before or during a crisis.

g. Ways to make their environment safe.

h. Follow up plan if crisis resumes or escalates.

4. MHD Program staff will incorporate the following interventions Safety plan Interventions

   a. Lethal Means Counseling includes:

      i. Discussing safe storage or removal of identified means for self-harm with the member and their support network.

         (1) Guns.

         (2) Sharp Instruments.

         (3) Medications.

         (4) Other weapons or instruments.

   b. Follow-up intensity may include, but is not limited to, the following:

      i. Establishing a follow-up schedule (e.g. daily, every few days, weekly) matching risk level identified in the C-SSRS Adult Assessment until risk is abated.

      ii. At each contact, re-assess for changes in ideation, behavior, protective factors, access to means, and adherence to Safety plan.

      iii. Ensure no gaps in care at transitions (e.g. discharge from inpatient settings must include scheduled outpatient follow-up prior to discharge).

      iv. Use warm handoffs (provider-to-provider introductions or shared calls) to improve continuity.

   c. Consider referring clients to a higher level of care depending on their risk level and any imminent act of suicide.

      i. Intensive settings to include:

         (1) Crisis Residential Unit.

         (2) Crisis Stabilization Unit.

(3) Inpatient Psychiatric Hospitalization.

M. Adverse Incident Event Review

1. MHD Program staff will adhere to the BHD Policy No. 7.1.16, *Unusual Occurrences and Sentinel Event Reporting,* and follow the policy and procedures for identifying and reviewing adverse incidents for clients in the MHD Program.

2. All Adverse Events/Unusual Occurrences must be documented using the Sentinel Event form (MHS 107) and should include the following events/problems, such as:

   a. Adverse medication reaction.

   b. Death of a client.

   c. Elopement.

   d. Homicide/attempt.

   e. Physical/sexual abuse of client.

   f. Physical/sexual abuse by client.

   g. Seclusion/restraint resulting in injury or death.

   h. Serious threat of harm to others.

   i. Significant delay in treatment resulting in harm to a client.

   j. Suicide/attempt.

   k. “Other” as identified by the clinical judgement of reporting staff person.

3. Designated DHS-BHD administrative personnel will meet monthly to review completed sentinel/adverse events.

   a. The review will consider ways in which adverse events can be mitigated in the future.

   b. Solutions towards improving the delivery of services for clients.

   c. Identify any procedures or workflows that warrant change or review to mitigate future adverse events.

   d. Identify steps for follow-up and remediation.

4. The adverse incident events review process will be reviewed and updated annually.

VI. Forms

MHS 107 Sentinel Event form

VII. Attachments

Attachment #1: Columbia Suicide Risk Assessment Procedure