

ACC COMMAND SURGEON NOTAM
RISK MANAGEMENT LESSONS
11 MAY 2004

The following Notice to Airmen (NOTAM) is released by the ACC Chief of Life Skills.

ATTENTION:
THE FOLLOWING IS AN OFFICIAL ACC/SG NOTAM
PLEASE PRINT, READ, AND DISSEMINATE TO ALL PERSONNEL ASSIGNED.

Target Audience: All personnel involved in providing services to mental health patients.

04-001: CARE COORDINATION FOR MENTAL HEALTH PATIENTS

Recent increases in suicide gestures, attempts and completions within ACC underscore the importance of diligently maintaining our awareness of airmen who may be at increased risk for attempting suicide. Over the last 2 years, the energy spent in our suicide prevention program resulted in significant reductions in the number of suicides across the command. However, increased vigilance is needed to ensure these trends continue during our accelerated operations and deployments tempo.

One of the clear lessons learned by examining ACC suicides in CY 2003 is the importance of connectivity between squadron leadership, the Life Skills Support Center (LSSC) staff and primary care managers (PCM). This connectivity will ensure the entire chain of command remains focused on identifying and preventing suicide. There have been several examples where hand-offs between squadron leadership, PCMs, and LSSC staff have been lacking. We owe it to our airmen to ensure effective communication and coordination between health care providers and command leadership.

EXAMPLES OF COMMON PROBLEMS IN CARE COORDINATION
FOR HIGH-RISK MENTAL HEALTH PATIENTS

1. NO FOLLOW-UP ON REFERRAL TO LSSC AFTER PCM VISIT: A suicide victim at one facility was seen by his PCM for psychotropic medication refill due to the unexpected absence of his psychiatrist. During this visit, he briefly discussed his stressors with his PCM. The PCM verbally referred him back to the LSSC. The patient did not schedule a follow-up at the LSSC and the PCM did not follow-up on his verbal referral. Referrals should be formally and adequately tracked to ensure opportunities for further intervention are not missed.

2. NO REASSESSMENT OF TREATMENT PLAN BASED ON NEW RISK FACTORS: A patient at one installation had been assessed in ADAPT following a DUI. There was no diagnosis or treatment apart from alcohol awareness education. This patient was later hospitalized for suicidal ideation. Upon release from the hospital, the patient was given a diagnosis of Alcohol Abuse. This diagnosis was largely ignored and

no referral was made to the ADAPT program for re-evaluation. An opportunity for further intervention was lost and this patient committed suicide 2 months after release from the hospital.

3. LSSC PROVIDERS FAILED TO COMMUNICATE RELEVANT CLINICAL INFORMATION: In 2003/2004, two ACC suicide victims were being seen by separate providers – a psychiatrist and a social worker. The LSSC providers were informed by their patients that the other provider’s patient was increasingly depressed. Neither LSSC provider passed this information to the other provider until after the suicide was completed. If the information had been passed between the providers it may have altered the formal treatment plan for these patients. The LSSC lacked a formal procedure for staffing “high risk” cases that need a multidisciplinary treatment approach.

4. NO CONTACT BETWEEN UNIT AND LSSC AFTER ARREST OVER THE WEEKEND: An LSSC patient was arrested and charged over the weekend with shop lifting. Because the member had a long history of administrative actions from which the commander had observed the member to quickly “bounce back,” the commander elected not to make an immediate referral to the LSSC. The commander was unaware of other marital stressors. The First Sergeant scheduled to take the member to the LSSC the Monday following the event. The member committed suicide hours after release from incarceration.

RECOMMENDATIONS

LSSCs should have risk assessments in their intakes and follow-up documentation, that take into account current and historical risk factors to determine a level of risk (i.e., minimal, mild, moderate, severe, and extreme.) The Air Force Guide for Managing Suicidal Behavior is an excellent resource for this procedure:

- LSSCs should consider periodic and regular use of a screening tool (e.g., OQ-45) with every patient
- Ensure LSSCs train all MH support staff who book new patient appointments to ascertain whether the patient has been seen at any other LSSC or are currently having suicidal, homicidal ideations

LSSCs must assure adequate tracking and communication of complex cases occurs. One example of how this could be accomplished would be through weekly Multidisciplinary Treatment Team Meetings:

- To discuss complex cases and share the perspectives and opinions of its members
- To formulate appropriate treatment plans based upon the recommendations of psychiatry, psychology, and psychological testing
- To provide peer support during cases in which strong Axis II factors cause significant stress on the provider and the organization

- These team meetings must include other disciplines (e.g., PCM, internist, etc.) if patients are under the care of a medical provider for high-risk issues such as chronic pain
- Ensure lateral communication between disciplines and document verbal recommendations/referrals to include FSC and Legal office

MDG must have pertinent operating instructions on:

- Missed Appointments and No Shows to include documentation of every cancellation with provider co-signature
- Referral procedures from primary care to LSSC
- Contingency plan to ensure continuity of care for unforeseen provider absences
- Establish procedures to make immediate contact with all “high risk” patients that are no-shows for LSSC appointments
- The use of a high-risk list for tracking patients who are at high-risk for suicide

Establish close working relationships within the bounds of confidentiality between LSSCs and line commanders

- Use AFMS tools such as the “Communicating with Commanders” video to strengthen skills in this area
 - Dialogue with squadron leadership about the “Leaders Guide for Managing Personnel in Distress” to increase clarity and understanding of LSSC roles
- Develop plans with unit leadership on how to manage high-risk airmen who experience stressful events during non-duty hours

Ensure all patients undergo comprehensive re-evaluation after psychiatric hospitalization and if possible make contact with patient the same day patient is discharged:

- Treatment plans need to be reassessed based on new diagnoses and risk factors

References:

1. Air Force Guide for Managing Suicidal Behavior: Strategies, Resources and Tools, 2003, Air Force Medical Operations Agency.
2. Managing Suicidal Behavior: Consultation with Commanders, 2003, Air Force Medical Operations Agency Training Video (614292)