

Suicide Protocol Development

Introduction

Suicide remains a common devastating outcome for many veterans. Known risk factors for suicide include older age, male gender, current depression, history of past suicide attempts, use of alcohol or other drugs, lack of social support, irrational thought processes (due to mental illness, drug use, or other causes), impulsivity, and chronic medical illness or disability. Many veterans are clearly at high risk. Sequae of a suicide include significant negative outcomes for the patient's family, provider and health care system. Standard of care for today's health care system should include highly functional and integrated systems to respond to the suicidal patient. However, many health care sites lack these systems or if they have them, they exist on paper and are not functional or integrated across service lines.

TIDES/WAVES is an ongoing project designed to facilitate care of depressed patients through collaboration between primary care and mental health. In these projects, a nurse care manager coordinates care, facilitating communication between primary care providers and mental health, and providing patient education, and tracking patient progress. The Collaboration Workgroup (CWG) of TIDES/WAVES focuses on establishing collaboration between primary care, depression care managers, and mental health services. The CWG is composed of psychiatrists, psychologists, nurse care managers, and researchers, representing 9 clinics across 3 VISNs in addition to the research team. One task of the CWG was to assure highly functional protocols to address the suicidal patient at each clinical site. In TIDES/WAVES many different clinical sites are enrolled. These sites are very different in size, structure, and resource allotments. The CWG had to appreciate these differences and make recommendations that focus on clinical priorities common to all sites. These recommendations also needed to be flexible enough to be useful to all sites.

The following is a summary of the CWG from TIDES/WAVES work on suicide protocol development. It may be useful for other clinical sites interested in developing suicidal protocols at their sites.

Establishing a Suicidal Patient Response Protocol

PLAN

1. Develop a team
 - Composition of the team should include members across service lines
 - Representation should include personnel from mental health, primary care, emergency services, support staff, and administration
2. Establish goals of the team

3. Review the site's existing protocol, including the use of test cases (or information from actual cases in which the protocol was activated), identifying weaknesses in the current protocol and prioritizing required changes.
4. Decide how the severity of the incident will be evaluated. Options include a standard assessment, a computer-scored screening tool, or other methods of follow-up to spontaneous mention of suicidal thoughts. CWG members thought that anytime a patient spontaneously mentions suicidal ideation it should receive a high priority resulting in some form of action
5. Determine who should be involved in evaluation and intervention. The CWG identified an overall "chain of responsibility" as more important than membership of any particular discipline. It was, however, felt to be important to include a mental health specialist (not necessarily an MD and not necessarily a "team"). The variable rated most important and most feasible in this area was "Incident reports/progress notes require co-signatures." Thus, communication with supervisors/primary physicians, etc. by the treating clinician is highly important. Defining this chain of responsibility needs to begin with the clerk or other support staff who may happen to take a call from a person who mentions suicide. Clearly defining whom the clinician is who will provide assessment and intervention in this situation is highly important.
6. Identify documentation requirements.
 - Documentation is an important part of the institution's response to any clinical situation. The CWG concurred that documentation in a progress note is highly important. The development process should take into account the informatics environment: are electronic records systems available to all clinicians (this would be a given in the VA but might not be in other settings), do clinicians rely on computerized records to communicate with each other, is there support for locally-developed software that captures variables unique to that site, etc. Some sites may wish to develop their own software programs to assess, document, and communicate about suicidal patients, while others may feel that their needs are served by the existing hospital software.

DO

1. Test the response protocol.

Another critically important aspect of developing a suicide response policy is testing the logistics of the situation. This is especially true when an emergency arises after hours (e.g., at the switchboard of a large hospital) and the appropriate clinician must be paged, called to the telephone, etc.

 - If possible, tests of the protocol with mock patients might be performed before actually mandating the protocol in clinical situations. Then the protocol could be refined as necessary.
2. Implement the protocol

-All personnel who will be directly involved in carrying out the steps of the protocol need to know and understand their roles, and administrators need to support their staff in carrying out the steps.

3. Educate employees about the protocol ensuring that involved parties are aware of what to do and what to expect. In-person seminars or training sessions would provide time for questions from clinicians, but might be seen as too much of a time burden. In that case, it might help to have a designated “expert” who was involved in creation of the protocol and can answer relevant questions.

STUDY

1. Evaluate the results. Periodic reevaluation of the protocol will be important as the facility changes (increased patient load, decreased staff numbers, altered hours of operation). It is most efficient if one point person organizes this review, consulting with other staff members as needed.

2. Determine effectiveness of response protocol. Ask the hard questions: Did the process work? Were the directions clear?

3. Draw conclusions and make recommendations for improvement.

ACT

1. Standardize the protocol
2. Introduce to other VISN facilities
3. Monitor so quality improvement can be maintained

Document produced by TIDES/WAVES Collaborative Care Workgroup. Contributors include Karen Vollen, Brad Felker, Laura Bonner, Barbara Simon, Barb Revay, Karen Berry, Scott Ober, Ed Chaney, Linda Worley, Scott Sherman, John Fotiades.