If you've cared for patients with suicidal ideation, you'll know how valuable this tool can be.

Immediate Action Protocol:

A TOOL TO HELP YOUR PRACTICE ASSESS SUICIDAL PATIENTS

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Most of us have experienced the anxiety, stress and disruption in our daily routine that occurs when we see a patient who has suicidal thoughts. As practices implement systems to routinely screen for and manage depression, more patients with depression and suicidal ideation will be uncovered.[1-3] Most of the depression-screening tools[4-7] used in primary care practices include questions surrounding two statements: "I would be better off dead" and "I have thoughts of harming myself." We must be ready to respond when a patient admits to having these thoughts.[8]

Case study

In an ongoing study of postpartum depression screening,[9] we asked family medicine practices to screen all postpartum women using the Edinburgh Postnatal Depression Scale. The study found that 7.6 percent – 70 of 922 – of the postpartum women screened reported suicidal thoughts that required further evaluation. To help the practices involved in the study evaluate these patients efficiently and effectively during the course of their busy practice schedules and initiate immediate action when needed, we developed a simple two-page tool called the Immediate Action Protocol, or IAP. (The IAP is shown on page 19. You can download a pdf from the online version of this article at http://www.aafp.org/fpm/20090900/17imme.html.)

Using the Immediate Action Protocol

The first page of the IAP lists questions for the physician to ask the patient that are designed to help elicit a more specific assessment of the risk that the patient will act on his or her suicidal thoughts.[8,10,11] The tool provides the general content of the questions and suggests ways to engage the patient so that answers can be obtained.

The second page of the tool lists the telephone numbers of local referral sources that can be used to obtain a more detailed assessment of suicide risk or for immediate treatment. The tool also includes a reminder regarding the physician's right and obligation to initiate a legal hold for further evaluation in the event that the patient is considered to be a risk to himself or herself or others but does not agree to further immediate assessment.

The material included in the IAP is simple, and your practice may already have a procedure in place for assessing patients' suicidal thinking. Still, even though many of the practices in our study had experienced the need to evaluate patients for suicide risk, none of the 28 practices had this information easily accessible. Physicians and staff

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found the tool helpful, easy to update and usable in both electronic and paper formats.

To enhance usability, readability and durability of the form, we typed the resource information and laminated several copies for each practice. The forms were placed in appropriate locations such as near the nurses' telephone line, on physicians' desks and at receptionists' stations. We printed them on colored paper so they would be easy to find among other papers.

Most practices do not have information readily available for assessing and referring suicidal patients.

The Immediate Action Protocol (IAP) helps practices evaluate suicidal patients quickly and efficiently, and it makes referral information more accessible.

Print the IAP on colored paper and place it where physicians, nurses and receptionists can find it quickly.

Put this tool to use

Adding an unexpected assessment for suicide risk to a full day's schedule of patient visits is challenging no matter how good your tools are, but having a ready-to-use resource available greatly facilitates the process. And if you have cared for a patient who committed suicide, you understand the importance of an effective, efficient system that focuses the assessment and assures quality care. FPM

Send comments to **fpmedit@aafp.org.**

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IMMEDIATE ACTION PROTOCOL (IAP)

Use this plan of action if any of the following are true:

a. The patient reports suicidal thoughts – either **passive**, "I would be better off dead," or **active**, "I have thoughts of harming myself."

b. The patient scores very high on a depression-screening tool.

c. The patient reports suicidal thoughts on a depression-screening tool.

d. Clinical judgment suggests concern about suicide.

STEP ONE: ASSESS SUICIDE RISK

- Use the suicide risk assessment questions, below, or
- Make an immediate (same-day) referral to a mental health professional who has access to an inpatient psychiatric facility or to an emergency department. (For referral information, see the second page.)

Suicide risk assessment questions:

Intent – *You have said that you think about killing or harming yourself or that you would be better off dead. Do you still feel that way?* (Directly asking about suicidal ideation is important and does not increase the patient's likelihood of suicide or of considering suicide. Many patients find it a relief to finally be able to discuss their thoughts and plans.)

Means – *Tell me about your plans and how you have thought about killing or harming yourself.* (The point is to identify the patient's plans, the planned method and the patient's access to weapons, drugs or other methods mentioned.)

Likelihood – *Do you think you would actually carry out these plans*? or *How likely do you think it is that you will carry out your plans*? (This is especially useful in identifying those who state that, although they think about suicide, they would never do it because it would leave their children without a mother or father or they don't think they could ever bring themselves to leave their family. It is also helpful when the answer is "very likely," "Why not? No one cares," etc.

Impulsivity – *Have you harmed yourself or attempted suicide before?* (Factors such as alcoholism, drug use or a history of previous attempts suggest impulsive behavior or episodes of reduced control and should increase concern about current thoughts.)

NEXT STEPS

- If the response to any of the above questions is positive or worrisome, then immediate referral for a more in-depth evaluation or inpatient management is strongly recommended. (For referral information, see the second page.)
- If the clinician has a concern about active suicidal thought but the patient is on the phone, ask to speak with another adult in the house to alert him or her to the situation.
- If no other person is available in the house and there is an immediate concern, keep the person on the phone and notify another staff member to dial 9-1-1. Do not disconnect the phone call. Dispatch an ambulance/police and stay on the phone until someone arrives. Establish a verbal "No Suicide Contract" until help arrives.

In most states, physicians have the legal right and obligation to assure that the suicidal patient is protected from self-harm. This usually includes the legal right to initiate a 24-hour to 72-hour involuntary "hold" for inpatient mental health assessment.

Immediate referral resources:
The following resources should be considered when the primary care physician has determined the need for referral of the patient for immediate (same-day) assessment for suicide risk:

	NAME OF FACILITY	TELEPHONE NUMBER	ADDRESS
Outpatient facility			
Inpatient facility			
Mental health center			
Crisis facility			
Emergency department			
Other			

Next step referral resources:
The following resources should be considered when the primary care physician has determined the patient is at risk for suicide (see the suicide risk assessment on the previous page):

	NAME OF RESOURCE	TELEPHONE NUMBER	ADDRESS
Local psychiatrist/mental health professional			
Local hospital			
Local ED for admission			
Suicide help line			
Distant psychiatrist consultation			
Other			

Transportation resources:
If the patient is resistant to inpatient management, non-family transportation may be required.

	TELEPHONE NUMBER
Police	
Ambulance	
Other	