

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	