RN Role in Suicide Prevention

Every patient, every visit: Two Question Screen: PHQ-2

POSITIVE response to either question, or Clinical Concern, administer PHQ-9*

Consider referral to Behavioral Health and PCP

If score is above 0 on Item #9 of PHQ-9, conduct risk assessment

Assess Level of Risk** using the Columbia Suicide Severity Rating Scale

LOW RISK

- Some thoughts of death; no plan or attempt behavior
- Some support systems in place
- Willingness to seek treatment
- Minimal use of substances if at all

IMPLEMENT NEXT STEPS

- Involve BHC if available
- Give Crisis Hotline numbers (1.800.273.8255)
- Discuss securing firearms or lethal medications
- Identify family member or support person to monitor
- Follow up appointment with PCP (within 2-4 weeks)

MODERATE RISK

- Suicidal ideation, vague plan, with or without access to means
- May have had a previous attempt

IMPLEMENT NEXT STEPS

- Handoff to provider or BHC

HIGH RISK

- Persistent ideation
- Suicide plan with strong intent and/ or possible rehearsal behavior
- Access to means
- Severe psychiatric symptoms and/or acute precipitating event
- May have had a previous attempt

IMPLEMENT NEXT STEPS

- Handoff to provider or BHC
- Ensure someone is with the person at all times

*Consider Risk Factors, Protective Factors and Warning Signs throughout (refer to list included on the backside of this diagram).

**Risk levels are fluid. A patient can move from one to the other.

Note: Some patients can be suicidal and not depressed - please refer to warning signs on the reverse

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Risk Factors, Protective Factors, and Warning Signs

WARNING SIGNS

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

RISK FACTORS

- Prior suicide attempt
- Misuse/abuse alcohol/other drugs
- Mental disorders (depression, etc.)
- Access to lethal means
- Knowing someone who died from suicide
- Social isolation
- Chronic disease/disability
- Lack of access to BH care
- End of relationship or marriage
- Death of a loved one or pet
- An arrest
- Serious financial problems

PROTECTIVE FACTORS

- Effective BH care
- Close connections to individuals, family, community & social institutions
- Life skills (coping, problem-solving)
- Self-esteem/sense of purpose or meaning
- Cultural, religious, or personal beliefs discouraging suicide

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