# 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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