NCLEX MENTAL HEALTH · PSYCHOSOCIAL INTEGRITY

SAFETY · CRISIS · ASSESSMENT

Suicide & Risk Assessment

A clinical emergency. Safety is always the first priority — and asking the question saves lives.

HIGH-YIELD
2026 TEST PLAN
PSYCH NURSING

"Are you thinking about killing yourself?"
Asking directly does not plant the idea — it opens the door to help.

#1
Prior attempt is the strongest predictor of future suicide.

01 Definition & Overview

YELLOW

Suicide is an **intentional, self-inflicted death** *. Suicidality exists on a continuum — assessment is rapid, and* **safety** *is uncompromising.*

KEY TERMS

- **Suicidal Ideation (SI):** thoughts of ending one's life
- **Passive SI:** "I wish I wouldn't wake up"
- **Active SI:** "I want to end my life"

CONTINUUM

- Ideation → Plan → Intent → Attempt
- **Lethality** rises with each step
- Specificity = imminence

WHY IT MATTERS

- Leading cause of preventable death
- Safety supersedes other priorities
- Nurse is often the **first responder**

02 Risk Factors & Pathophysiology

RED

1 Biological Vulnerability
5-HT & HPA-axis dysregulation; family history; chronic pain or terminal illness.

2 Comorbid Mental Illness
Depression, bipolar, schizophrenia, PTSD, borderline PD, substance use disorder.

3 Psychological State
Hopelessness, perceived burden, thwarted belonging, intolerable pain.

4 Precipitating Trigger
Loss, crisis, humiliation, anniversary dates, discharge, access to means.

5 Tipping Point
↓ ambivalence + energy + means = **imminent risk**. Prior attempt = #1 predictor.

HIGHEST-RISK GROUPS

- Older adult white males (>65)
- Adolescents & young adults
- LGBTQ+ youth
- Veterans & first responders

MODIFIABLE FACTORS

- Substance use
- Access to lethal means
- Untreated mental illness
- Social isolation

PROTECTIVE FACTORS

- Strong social support
- Connectedness to community
- Religious / spiritual belief
- Effective mental health care

03 Warning Signs & Red Flags

ORANGE

Early / Subtle Signs

- Social withdrawal; isolation from loved ones
- Mood shifts — sadness, anger, anxiety, irritability
- Sleep disturbance (insomnia or hypersomnia)
- Increased substance use
- Statements of being a *burden* to others
- Hopelessness, helplessness, worthlessness
- Decline in self-care & hygiene
- Loss of interest in previously valued activities

Imminent / Red Flag Signs

RED FLAG

- **Specific plan** with means, time, and place
- **Giving away** prized possessions
- **Putting affairs in order** — wills, goodbyes
- Talking or writing about death & suicide
- Researching methods of self-harm
- Saying goodbye in unusual ways
- Acquiring access to lethal means

⚠ **MOST MISSED SIGN:** A **sudden calm or improvement** after deep depression. The patient now has *energy* to act on a plan they've already made. This is a **RED FLAG**, not recovery.

04 Priority Nursing Interventions

GREEN

Apply **ABCs → Safety → Therapeutic communication**. *The patient at imminent risk is* **never left alone**.

1 SAFETY · #1 **Ensure immediate safety.** Never leave a patient with active SI + plan/intent alone. Initiate continuous observation; remove harmful items.

2 ASSESS **Ask directly.** "Are you thinking about killing yourself?" Assess **ideation → plan → means → intent → timeline**. Use **C-SSRS**.

3 IMPLEMENT **Initiate suicide precautions** at the appropriate level. Calm, low-stimulation environment. Room & belongings search per policy.

4 COMMUNICATE **Therapeutic communication.** Stay present. Listen without judgment. Validate emotional pain — *not* the plan. Avoid platitudes.

5 COLLABORATE **Collaborate on a safety plan** (Stanley-Brown). **Do NOT** use outdated "no-suicide contracts" — they are not evidence-based.

6 DOCUMENT **Document precisely.** Use patient's *exact words* in quotes. Record assessment, precautions, interventions, response, notifications.

LEVELS OF SUICIDE PRECAUTION

LEVEL · HIGH
1:1 Continuous
Staff within **arm's length** 24/7, including bathroom & sleep. Active plan, recent attempt, or persistent intent.

LEVEL · MODERATE
Q15-Minute
Visual checks every 15 min. SI without active plan or strong intent. Document each check.

LEVEL · LOW
Routine + Plan
Standard observation with active safety planning, follow-up, and means restriction.

05 Pharmacology

PURPLE

Medications treat the **underlying disorder**. *Two drugs have specific evidence for* **reducing suicide risk**: **lithium** *(bipolar) and* **clozapine** *(schizophrenia).*

SSRIs / SNRIs ANTIDEPRESSANTS

MECH — ↑ synaptic serotonin (± NE) → mood elevation over 2–6 weeks.
SIDE FX — GI upset, sexual dysfunction, insomnia, serotonin syndrome.
NURSING — Monitor closely weeks 1–6 — energy returns *before* mood lifts.

⚠ BLACK BOX: ↑ suicidal ideation in patients < 25 yrs, esp. early treatment.

Lithium MOOD STABILIZER

MECH — Modulates neurotransmission & 2nd messengers; stabilizes bipolar mood.
SIDE FX — Tremor, polyuria, weight gain; **narrow therapeutic index** 0.6–1.2 mEq/L.
NURSING — Monitor levels, renal & thyroid function, hydration, Na+ intake.

★ EVIDENCE: reduces suicide risk in bipolar disorder.

Clozapine ATYPICAL ANTIPSYCHOTIC

MECH — D2 / 5-HT2A antagonism; reserved for treatment-resistant schizophrenia.
SIDE FX — **Agranulocytosis**, seizures, myocarditis, metabolic syndrome.
NURSING — Weekly → monthly ANC monitoring under **REMS**.

★ EVIDENCE: FDA-approved to reduce suicide in schizophrenia.

Esketamine (Spravato) NMDA ANTAGONIST

MECH — Intranasal; rapid onset for treatment-resistant depression with acute SI.
SIDE FX — Dissociation, sedation, ↑BP, dizziness, nausea.
NURSING — REMS-certified setting; 2-hr post-dose monitoring; no driving same day.

UNIVERSAL MEDICATION SAFETY PEARLS

- **Dispense small quantities** at discharge — limit available supply.
- **Monitor adherence** — abrupt discontinuation worsens risk.
- **Supervise administration** inpatient; check for "cheeking."
- **Educate family** on safe storage & reporting new symptoms.

06 NCLEX Test Traps

BROWN

⚠ TRAP
"Asking about suicide may give the patient the idea."
✓ TRUTH
Direct questions do NOT plant the idea. Asking is therapeutic; always the correct answer when offered.

⚠ TRAP
"The patient seems brighter — they're getting better."
✓ TRUTH
Sudden improvement is a RED FLAG. Patient may have a plan and feels relief. Increase observation.

⚠ TRAP
"Have the patient sign a no-suicide contract."
✓ TRUTH
Contracts are outdated. Use evidence-based *safety planning* (Stanley-Brown).

⚠ TRAP
"I'll keep this between us." (Confidentiality reassurance)
✓ TRUTH
Never promise confidentiality for safety-related disclosures. Information must be shared with the team.

⚠ TRAP
"He only said he wished he wouldn't wake up — not suicidal."
✓ TRUTH
Passive SI is still SI. Assess fully, document, and escalate. Can progress rapidly.

⚠ TRAP
"Therapeutic communication is the priority intervention."
✓ TRUTH
Safety comes before communication. For imminent risk, stay with patient and initiate precautions *first.*

07 Patient & Family Education

TEAL

Stanley-Brown Safety Plan — 6 Steps

1. **Warning signs** — personal thoughts, moods, situations that precede crisis.
2. **Internal coping** — distraction, exercise, music, prayer, grounding skills.
3. **Social contacts & settings** — people / places that distract & connect.
4. **People to ask for help** — trusted family, friends; aware of the plan.
5. **Professionals & agencies** — therapist, prescriber, 988, ED.
6. **Make environment safer** — collaborative means restriction with support person.

Crisis Resources

SUICIDE & CRISIS LIFELINE

988

Call or text — 24/7, free, confidential. Press 1 for Veterans line, 2 for Spanish.

CRISIS TEXT LINE

Text HOME → 741741

For those who prefer to text rather than call.

Teach family: take ALL statements seriously, listen without arguing, restrict access to lethal means, accompany the patient, and **never leave them alone** in crisis.

HIGH-YIELD EDUCATION POINTS

- **Highest risk:** first 30 days post-discharge — appointment *before* discharge.
- **Means restriction** works — collaborate with family to secure the home.
- **Reduce isolation** — daily contact, structured routine.
- **Adherence:** never stop psychiatric medication abruptly.
- **Substance use** raises impulsive risk — treat both.
- **Follow-up call** within 24–48 hr of discharge reduces re-attempt.

08 Memory Boosters & Mnemonics

GOLD

SAD PERSONS

RISK-FACTOR SCREEN

- **S** Sex (male)
- **A** Age (<19 or >45)
- **D** Depression
- **P** Previous attempt
- **E** Ethanol / drugs
- **R** Rational thinking loss
- **S** Social support lacking
- **O** Organized plan
- **N** No spouse
- **S** Sickness (chronic)

IS PATH WARM

IMMINENT WARNING SIGNS (AAS)

- **I** Ideation
- **S** Substance abuse
- **P** Purposelessness
- **A** Anxiety / agitation
- **T** Trapped
- **H** Hopelessness
- **W** Withdrawal
- **A** Anger / rage
- **R** Recklessness
- **M** Mood changes

Pattern Recognition — Three Pearls

> *"Past predicts future."*
> Prior attempt is the strongest predictor — always weight it heavily on the exam.

> *"Sudden calm = danger."*
> Improvement after deep depression often signals a finalized plan + restored energy.

> *"Ask directly, document exactly."*
> Direct questioning is always therapeutic. Quote the patient's own words verbatim.