The role of psychiatric nurses in suicide risk assessment, crisis intervention, and continuity of care: A patient-centered review

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Abstract:
Suicide prevention in psychiatric services requires more than identification of a numerical risk category. It requires clinicians to recognize fluctuating distress, understand the person's reasons for living and reasons for dying, respond to immediate danger, preserve therapeutic connection, and maintain continuity when the patient moves between emergency, inpatient, outpatient, and community settings. Psychiatric nurses occupy a central position in this continuum because they frequently have the most sustained contact with patients and families and are therefore well placed to detect changes in affect, behavior, engagement, cognition, substance use, environmental safety, and access to support. Current guidance emphasizes person-centered psychosocial assessment, clinical formulation, collaborative safety planning, restriction of access to lethal means when feasible, compassionate crisis management, and coordinated follow-up rather than reliance on a single scale or a global label such as "low" or "high" risk. Evidence also indicates that the period after psychiatric discharge is particularly vulnerable and that timely outpatient contact, structured follow-up, and caring contacts can strengthen continuity. This patient-centered review examines the psychiatric nurse's role across assessment, crisis intervention, therapeutic engagement, inpatient management, discharge planning, family partnership, follow-up, professional training, documentation, ethical practice, quality improvement, and emerging digital care models. The review highlights how nursing practice can connect risk recognition with individualized action while avoiding false precision, coercive routines, and fragmented transitions.

Keywords:
Psychiatric nursing; suicide risk assessment; suicide prevention; crisis intervention; safety planning; therapeutic relationship; continuity of care; post-discharge follow-up; patient-centered care; mental health nursing.

1. Introduction:

Suicide is a major public health concern and a recurrent clinical challenge across mental health services. The World Health Organization reports that more than 720,000 people died by suicide in 2021 and emphasizes that suicide has multiple interacting social, psychological, biological, cultural, and environmental determinants (World Health Organization, et al., 2025). For health professionals, the challenge is not simply to identify who may be at risk, but to recognize when a person's safety is changing and to connect assessment findings with practical, compassionate interventions. The psychiatric nurse is often positioned at the point where these needs meet. Nurses observe patients repeatedly, hear changes in narrative that may not be visible in a single interview, monitor behavior in real time, support medication administration and physical care, engage families, and help coordinate transitions across services. A contemporary nursing response therefore needs to integrate clinical vigilance with relationship-centered practice rather than separating "risk management" from ordinary therapeutic care. Suicidal thinking is dynamic. Risk can increase or decrease with changes in mood, intoxication, sleep, interpersonal stress, treatment response, access to means, perceived burdensomeness, hopelessness, agitation, psychosis, and social connection. Turecki et al. emphasize that suicidal behavior emerges from interacting vulnerabilities rather than one simple causal pathway (Turecki et al., 2019). Similarly, the large longitudinal evidence base summarized by Franklin et al. found that commonly cited risk

factors have limited accuracy when used as stand-alone predictors of future suicidal behavior (Franklin et al., 2017). This creates an important implication for nursing: assessment is most useful when it is used to understand the individual's current needs, identify modifiable conditions, and plan protective action. It is less useful when it is treated as a one-time exercise that produces a permanent category. Recent standards reinforce this principle. NICE recommends that professionals do not use risk assessment tools or global "low, medium, high" classifications to predict future suicide or to decide who should receive treatment or be discharged. Instead, mental health professionals are directed toward psychosocial assessment and risk formulation that considers immediate and longer-term safety (NICE, 2022). The Joint Commission similarly emphasizes validated screening, evidence-based assessment, and documentation of risk-mitigation plans, environmental safety, staff competence, monitoring, and discharge follow-up (The Joint Commission, 2026). For psychiatric nurses, these expectations translate into an active clinical role: ask directly, listen carefully, identify change, communicate concerns, mobilize resources, support collaborative planning, and remain engaged through transitions of care.

2. Review Perspective and Patient-Centered Scope:

This article presents a narrative, patient-centered review of the psychiatric nurse's role in suicide risk assessment, crisis intervention, and continuity of care. It synthesizes current international guidance, evidence on suicide risk assessment, nursing education, therapeutic relationships, safety planning, post-discharge risk, and care transitions. The objective is not to create a rigid protocol that substitutes for clinical judgment. Instead, the review organizes the literature into a practical nursing framework that can be adapted to local law, professional scope, institutional policy, and the needs of the person receiving care. A patient-centered approach begins with the recognition that suicidal distress is experienced by a person, not by a score. Screening instruments may help identify people who need fuller assessment, and some structured instruments have demonstrated validity for describing suicidal ideation or behavior. For example, Posner et al. reported favorable psychometric findings for the Columbia-Suicide Severity Rating Scale, while Horowitz et al. developed the Ask Suicide-Screening Questions for rapid pediatric screening (Posner et al., 2011; Horowitz et al., 2012). These tools are most appropriately understood as components of a broader clinical process. Screening can open the conversation; it cannot replace the conversation. Patient-centered care also requires attention to the patient's voice. A nurse can ask what the patient believes is happening, what makes the present moment difficult, what has helped before, what would make the environment safer, and what kind of support feels acceptable. The patient's explanation may differ from the nurse's initial assumptions, particularly when self-harm, trauma, substance use, personality-related difficulties, psychosis, or intense interpersonal conflict is present. Riedel et al. identified relationship-building and communication as core nursing roles across the suicide prevention continuum, alongside assessment, risk management, collaboration, education, and self-management (Riedel et al., 2025). The implication is that patient-centeredness is not an optional communication style; it is part of the safety intervention itself.



Figure. 1: Patient-Centered Suicide Risk Assessment Workflow

3. Suicide Risk in Psychiatric Care:

Psychiatric services frequently care for people with conditions that can be associated with suicidal behavior, including depressive disorders, bipolar disorder, schizophrenia spectrum disorders, substance use disorders,

trauma-related conditions, and severe personality-related distress. Risk may also occur without a formal psychiatric diagnosis, and the presence of a diagnosis should never be used as a proxy for current suicide risk. Franklin et al. found that the predictive power of individual risk factors has generally been modest, while Turecki et al. described suicide as the outcome of interacting biological, psychological, social, and environmental pathways (Franklin et al., 2017; Turecki et al., 2019).

Nursing assessment should therefore attend to both enduring vulnerabilities and immediate changes. Previous self-harm or suicide attempt is clinically important because it indicates a history of suicidal behavior, but history alone does not determine what will happen next. Similarly, current suicidal ideation may vary in intensity, frequency, controllability, and relationship to a patient's environment. The nurse should assess whether thoughts are passive or active, whether they are becoming more persistent, whether the patient feels able to resist them, whether distress is escalating, and whether protective connections remain accessible. The goal is not to extract a perfect prediction. The goal is to understand the present situation sufficiently to reduce danger and support the patient's next safe step. Particular attention is required around transitions. Olfson et al. found substantial short-term suicide risk during the first 90 days after psychiatric discharge, especially among patients with depressive disorders, bipolar disorder, schizophrenia, and substance use disorders (Olfson et al., 2016). Chung et al. reported particularly elevated suicide rates during the first week and first month following psychiatric hospitalization, while emphasizing heterogeneity and the possibility of publication bias (Chung et al., 2019). These findings make continuity of care a core prevention issue rather than a secondary administrative task. A nurse who recognizes risk but fails to transmit the information to the next service leaves the prevention process incomplete.

4. The Psychiatric Nurse as a Clinical Observer and First-Line Assessor:

Psychiatric nurses are often the clinicians with the greatest opportunity to notice change over time. A patient may appear composed during a scheduled medical interview yet demonstrate increasing withdrawal, insomnia, pacing, abrupt changes in speech, reduced eating, medication refusal, increased substance use, giving away possessions, or statements of hopelessness during routine nursing interactions. These observations gain meaning when linked with direct inquiry and comparison with the patient's baseline. Riedel et al. described early detection, risk assessment, relationship-building, risk management, collaboration, and education as interrelated nursing responsibilities rather than isolated tasks (Riedel et al., 2025).

Initial nursing assessment should establish the reason for presentation, current level of distress, recent suicidal thoughts or actions, recent self-harm, known psychiatric symptoms, substance exposure, medical contributors, current treatment, relevant trauma or psychosocial stressors, social supports, and immediate environmental concerns. The nurse should also determine whether the person can participate in an interview, whether an interpreter or communication support is needed, and whether acute intoxication, delirium, severe psychosis, agitation, or cognitive impairment is affecting the reliability of the interview. Assessment is therefore both verbal and observational. Direct questions should be clear, calm, and nonjudgmental. The evidence does not support avoiding the topic out of fear that asking about suicide will create suicidal thoughts; instead, direct questioning is a central component of safe assessment. Structured screening can support consistency. However, the clinician should treat a positive screen as the starting point for fuller evaluation, not as a final diagnosis or discharge decision (NICE, 2022; The Joint Commission, 2026). A nurse who asks directly and then listens carefully helps transform an otherwise hidden safety concern into something that can be assessed and managed.

5. Structured Assessment: From Screening to Clinical Formulation:

Screening and assessment should be differentiated. Screening is generally brief and designed to identify people who may need further evaluation. Full assessment explores the nature and context of suicidal thinking or behavior, current mental state, contributing circumstances, protective factors, and access to means, previous patterns, and the individual's immediate needs. The Columbia-Suicide Severity Rating Scale was designed to quantify suicidal ideation and behavior and demonstrated good convergent and divergent validity in multisite studies (Posner et al., 2011). The ASQ provided a brief pediatric emergency screening approach with strong performance for identifying elevated risk requiring further evaluation (Horowitz et al., 2012). At the same time, the limitations of predictive scales are important. Carter et al. found low pooled positive predictive values for suicide and broader suicidal outcomes across clinical risk scales, reinforcing that a numerical threshold should not be interpreted as an accurate forecast of an individual's future behavior (Carter et al., 2017). NICE therefore advises against using scales to predict future suicide or decide discharge, and instead recommends psychosocial assessment and risk formulation (NICE, 2022). For nursing practice, this means that structured tools can improve completeness, but the final clinical picture must integrate narrative, observation, context, and change over time.

A comprehensive assessment can be organized around several domains: current suicidal thoughts and behaviors; intent and degree of control; recent escalation; psychiatric symptoms; substance use; medical status; stressors and losses; interpersonal context; previous attempts or self-harm; access to lethal means; reasons for living; treatment engagement; social supports; cultural context; and barriers to follow-up. The nurse should also identify what would make the patient feel safer during the next few hours and what is likely to increase risk. This converts an assessment from a static checklist into an actionable understanding of the patient's situation.

Table 1: Assessment: From Screening to Clinical Formulation

Assessment domain	**Key nursing focus**	**Examples of clinical action**
Suicidal thoughts and behavior	Nature, intensity, frequency, recent change, controllability, prior behavior	Direct questioning; document changes; escalate urgent concerns
Mental state	Mood, agitation, psychosis, hopelessness, anxiety, cognition	Increase observation or urgent review as indicated
Context and stressors	Losses, conflict, trauma reminders, financial or social pressures	Identify modifiable stressors and support needs
Means and environment	Access to potentially lethal methods and unsafe environmental features	Collaborate on means restriction and environmental precautions
Protective factors	Relationships, responsibilities, beliefs, goals, treatment alliance	Strengthen accessible protective connections
Continuity	Existing providers, medications, appointments, transport, communication needs	Coordinate handover and confirm next contact

6. Dynamic Risk Formulation: Moving Beyond "Low, Medium, High":

Risk formulation asks how risk is developing, what is driving it now, what might increase it, and what may reduce it. It differs from a single label because it preserves the patient's story and the clinician's reasoning. NICE explicitly recommends formulation within psychosocial assessment and advises against using global risk stratification as a predictor of future suicide or as a gate for treatment and discharge (NICE, 2022). Franklin et al. likewise demonstrated the limitations of prediction when risk factors are treated as isolated variables (Franklin et al., 2017). For psychiatric nurses, formulation can be made practical by separating static and dynamic elements. Static elements may include past suicide attempts, chronic psychiatric illness, or a history of trauma. Dynamic elements can include present hopelessness, agitation, intoxication, acute relationship rupture, command hallucinations, medication discontinuation, access to means, or rapidly worsening sleep. Protective factors include current relationships, willingness to accept help, connection to services, future-oriented goals, coping skills, and reasons for living. The key nursing task is to identify which dynamic elements can be changed during the current episode of care. Formulation should also include uncertainty. Suicidal behavior cannot be predicted with certainty, and the absence of stated intent does not guarantee safety. A patient may deny current intent because of shame, fear of admission, concern about consequences, fluctuating thoughts, or difficulty naming internal experiences. The nurse should therefore document observable evidence and patient statements without overstating certainty. A formulation might indicate that risk appears elevated because of recent suicidal behavior, severe agitation, intoxication, and loss of support, while also identifying specific factors that currently reduce danger and actions that will be taken if those factors change.

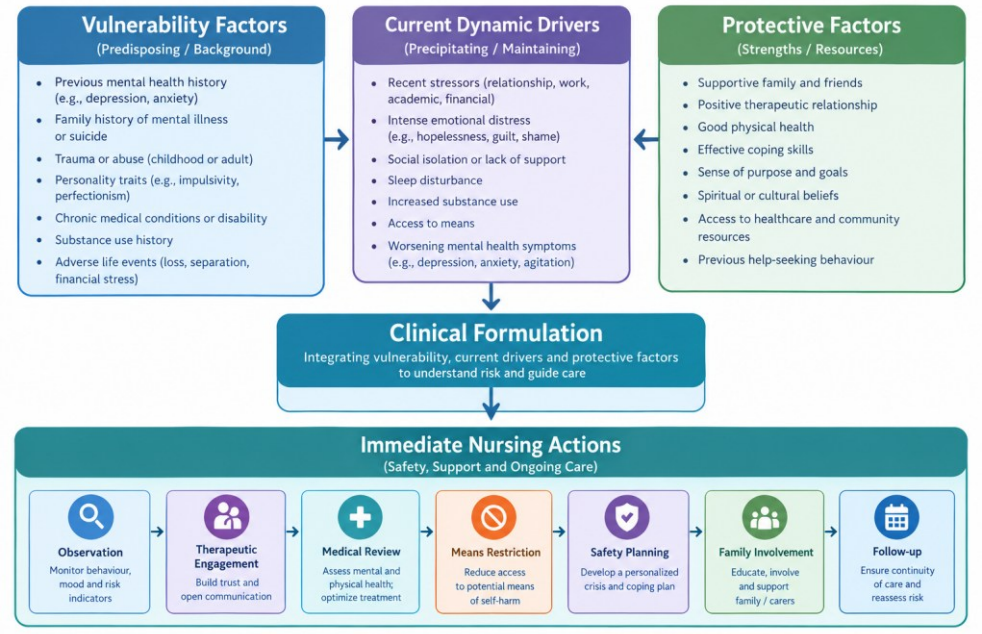


Figure. 2: Dynamic Suicide Risk Formulation in Psychiatric Nursing

7. Documentation and Communication as Safety Interventions:

Documentation is not merely a legal requirement; it is part of the safety system. A clear nursing note allows the next clinician to understand what changed, what was discussed, what the patient agreed to, what concerns remain, and what actions are planned. Good documentation distinguishes patient statements from clinician observations and from clinical interpretation. It should record the time and context of assessment, significant changes, protective factors, environmental precautions, communication with senior clinicians, family or support involvement where appropriate, and the plan for reassessment. Communication should be timely and structured. When risk changes, the nurse should use local escalation procedures and communicate to the responsible prescriber or senior mental health professional rather than waiting for routine rounds. Interdisciplinary communication is particularly important at shift changes and transitions. The Joint Commission emphasizes policies for reassessment, monitoring, staff competence, and discharge follow-up for patients identified as at risk (The Joint Commission, 2026). Riedel et al. also identified interdisciplinary collaboration as a distinct nursing role in suicide prevention (Riedel et al., 2025). A useful handover should answer practical questions: What happened? What is the patient experiencing now? What has changed from baseline? What does the patient say would help? What environmental concerns exist? What has been done? What remains unresolved? What is the next planned contact? Such communication preserves continuity even when staff or settings change. The patient should not have to retell the most painful parts of the story simply because the team failed to communicate. Continuity begins inside the organization, not only after discharge.

8. Crisis Intervention: Immediate Safety with Therapeutic Presence:

Crisis intervention begins when the patient is at immediate or rapidly increasing risk, but the purpose is broader than containment. The nurse must reduce immediate danger while simultaneously creating enough trust and psychological space for the patient to participate in care. A calm introduction, simple language, nonjudgmental questions, and a clear explanation of what the nurse is doing can reduce confusion during a highly emotional period. The nurse should avoid arguing with the person's feelings or offering simplistic reassurance. Statements such as "you have so much to live for" may close the conversation; statements that acknowledge distress and invite elaboration are more likely to support engagement. The immediate response depends on the clinical picture. Severe agitation, psychosis, intoxication, delirium, medical instability, or an active attempt may require urgent multidisciplinary intervention. The nurse may need to arrange a safer environment, increase observation, seek medical assessment, remove accessible means where permitted, reduce stimulation, and obtain senior review. WHO guidance emphasizes early identification, assessment, management, and follow-up for self-harm and suicide-related presentations, while the mhGAP guideline provides an evidence-based framework for assessment and management in a range of settings (World Health Organization, et al., 2023). Crisis intervention should be proportionate. Excessive restriction without explanation may increase distress, undermine trust, and make future help-seeking more difficult. The least restrictive safe response should be considered within local law and policy, while recognizing that immediate safety takes priority when there is

imminent danger. Riedel et al. highlighted the tension between special supervision as a preventive measure and the risk that supervision can become non-therapeutic when it is separated from empathy and planned therapeutic care (Riedel et al., 2025). This remains relevant to modern observation practices: safety monitoring should be relational as well as procedural.



Figure. 3: Crisis Intervention and Collaborative Safety Planning Pathway

9. Therapeutic Engagement and the Nurse-Patient Relationship:

The therapeutic relationship is one of the strongest nursing resources available during suicide prevention. A patient who feels respected is more likely to disclose distress, discuss ambivalence, accept help, and participate in a safety plan. Riedel et al. place relationship-building and communication alongside risk assessment and management as central nursing responsibilities (Riedel et al., 2025). Riedel et al. describe relationship-building, communication, collaboration, and organizational support as important components of nursing practice, while limited time and system pressures can constrain therapeutic work (Riedel et al., 2025). Therapeutic engagement does not require the nurse to agree with every patient belief or to remove every source of distress. It requires consistent presence, curiosity, respect, boundaries, and a willingness to stay with difficult content. Nonjudgmental language is especially important when the patient has repeated self-harm, substance use, or a history of interpersonal conflict. Labels that imply manipulation or attention-seeking can damage the therapeutic alliance and may discourage future disclosure. A patient-centered response instead asks what function the behavior serves, what distress precedes it, what the person hopes will change, and what safer strategies might provide relief. Nurses also need self-awareness. Suicidal behavior can evoke fear, frustration, helplessness, anger, or overprotection in clinicians. These reactions are human, but they should be recognized because they may influence communication and decision making. Ferguson et al. found that suicide-prevention education for nurses can improve knowledge, competence, and attitudes, although the evidence base has methodological limitations and longer-term changes in practice need further study (Ferguson et al., 2018). Woods et al. more recently reported improved suicide-related knowledge and attitudes following a brief web-based educational module for psychiatric-mental health nurses (Woods et al., 2024).

10. Safety Planning as a Nursing-Supported Intervention:

Safety planning translates assessment into a written, collaborative response for moments of escalating distress. It should not be confused with a "contract for safety," which asks the patient to promise not to harm themselves without establishing specific coping steps and supports. NICE recommends collaborative safety planning that identifies triggers and warning signs, individualized coping strategies, social contacts and settings for distraction, and practical actions related to means and crisis support (NICE, 2022). For psychiatric nurses, the safety plan can become a practical bridge between conversations, observation, discharge planning, and follow-up. Evidence supports the use of safety-planning approaches, although the strength of evidence varies across formats and populations. Stanley et al. reported that safety planning with structured follow-up was associated with fewer suicidal behaviors and greater treatment engagement among patients treated in emergency departments (Stanley et al., 2018). Nuij et al. found that safety-planning-type interventions were associated with a lower risk of suicidal behavior in meta-analysis, while not demonstrating a significant pooled effect on suicidal ideation (Nuij et al., 2021). Ferguson et al. similarly found promising evidence for safety planning in adults but emphasized heterogeneity across interventions and studies (Ferguson et al., 2022). A nurse-

supported safety plan should use the patient's own language and be easy to access. The plan may include personal warning signs, internal coping strategies, people and places that provide distraction or support, professional contacts, and specific steps for reducing access to means. The nurse should confirm that the patient understands the plan and can realistically use it. It is often helpful to rehearse one scenario: "Suppose your thoughts become much stronger tonight; what is the first sign you would notice, what you would do first, and who you would contact next?" Such rehearsal turns a document into a usable action sequence.

11. Lethal Means Safety and Environmental Risk Reduction:

Lethal means safety involves reducing access to highly dangerous methods during periods of elevated risk. At the patient level, the nurse can ask about access to medicines, weapons, toxic substances, or other relevant means and collaborate with the patient and, when appropriate, family or caregivers to reduce access. Runyan et al. demonstrated that hospital emergency departments can implement lethal means counseling as part of care for suicidal patients, highlighting its feasibility within routine practice (Runyan et al., 2018). Hunter et al. later reviewed lethal means restriction counseling in emergency departments and found substantial variation in how consistently it was delivered, supporting the need for training and system-level implementation (Hunter et al., 2021). Environmental safety applies inside psychiatric services as well. The physical environment should be reviewed for features that could be used to cause harm, and the patient's level of observation should match the clinical situation. The Joint Commission identifies environmental risk assessment as a key component of suicide risk reduction in psychiatric settings, along with validated screening, assessment, monitoring, staff training, and discharge planning (The Joint Commission, 2026). Environmental precautions, however, should be combined with therapeutic engagement. A highly restricted environment without relational support may reduce one type of immediate hazard while increasing distress or disengagement. Nurses are often central to environmental safety because they work within patient areas continuously. They can identify changes such as a patient searching for secluded areas, attempting to access restricted items, or becoming increasingly preoccupied with a means of self-harm. Any environmental concern should be communicated quickly according to local policy. Means safety should also be revisited when the patient's circumstances change, because an intervention that is adequate during a closely supervised inpatient stay may no longer be adequate when the patient returns home.

12. Observation, Inpatient Nursing, and Therapeutic Safety:

Observation levels are commonly used in psychiatric units when risk is elevated. Their purpose is to reduce immediate opportunity for self-harm while allowing the team to monitor changes and respond rapidly. Yet observation is most effective when it is individualized. Continuous or intermittent observation should have a clear clinical rationale, documented review, and defined communication process. Reid and Long emphasized that supervision can become non-therapeutic when nurses experience it as surveillance rather than as part of a planned therapeutic program (Riedel et al., 2025). This insight remains relevant because observation practices can unintentionally create emotional distance. The nursing approach during observation should therefore include purposeful interaction. The nurse can assess mood, distress, sleep, impulse control, psychotic symptoms, substance withdrawal, and willingness to engage. The patient can be reminded why the observation is being used and what would support its reduction. Collaborative language such as "we are increasing observation because we are concerned about your safety right now; let us work together on what could help us reduce it" communicates both responsibility and hope. Inpatient safety also depends on routine care. Sleep disruption, medication side effects, pain, constipation, hunger, interpersonal conflict, boredom, and lack of privacy may intensify distress. Psychiatric nurses are uniquely positioned to notice these factors and address them. A patient-centered safety culture therefore includes ordinary nursing care, not only emergency interventions. Suicide prevention is embedded in the quality of the therapeutic environment: predictable staff responses, respectful limit setting, meaningful activity, timely medical care, and opportunities for the patient to regain a sense of control.

13. De-escalation and Management of Acute Distress:

Acute suicidal distress may coexist with agitation, anger, panic, dissociation, psychosis, intoxication, or withdrawal. De-escalation begins with recognition of escalating arousal and a reduction in unnecessary stimulation. The nurse should adopt a calm tone, maintain appropriate interpersonal space, use short and clear statements, acknowledge emotion, and avoid confrontational debate. The aim is to restore enough regulation for assessment and collaborative decision making. When physical or pharmacological restraint becomes necessary under local policy, it should be used proportionately and accompanied by ongoing clinical review, documentation, and therapeutic follow-up. De-escalation also requires attention to staff behavior. Multiple

clinicians speaking at once, rapid questioning, visible frustration, or unexplained restrictions can increase fear. A designated lead communicator may reduce confusion during a crisis. The psychiatric nurse can often provide this stabilizing presence because nurses remain close to the patient while the medical and psychiatric team organizes urgent decisions. WHO guidance supports integrated assessment and management, with attention to medical and psychosocial needs rather than treating suicide-related behavior as a single isolated symptom (World Health Organization, 2023). After the immediate crisis settles, the nurse should return to the therapeutic conversation. The patient should have an opportunity to describe what happened, identify triggers, and participate in revising the safety plan. This reduces the risk that an acute event becomes only a security response. It also generates information that may improve the next episode of care. A crisis can reveal previously hidden drivers of suicidal behavior, such as medication nonadherence because of side effects, unsafe family conflict, substance use, poor sleep, or gaps in community care.

14. Interprofessional Collaboration:

Suicide prevention is inherently multidisciplinary. Psychiatric nurses collaborate with psychiatrists, psychologists, social workers, occupational therapists, pharmacists, primary care clinicians, emergency staff, and community services. The nurse often acts as a connector among these roles because nursing care touches assessment, medication administration, behavioral monitoring, patient education, family communication, discharge planning, and follow-up. Riedel et al. identified interdisciplinary collaboration as a core nursing role and emphasized the need for stronger organizational support for nurses' suicide-prevention contribution (Riedel et al., 2025). Collaboration should be based on shared clinical understanding rather than repeated parallel assessments. When each professional asks the same patient the same questions without communicating the answers, the burden may fall on the person at a time when concentration and trust are already limited. A coordinated approach can divide responsibilities: one clinician may complete a detailed psychiatric evaluation, the nurse may monitor changes and implement the safety plan, the social worker may address housing or family stressors, and the pharmacist may review medication access and safety. The patient should understand who is responsible for what. Communication is especially important when the patient's stated goals differ from the team's immediate safety concerns. The nurse can support a shared discussion of benefits, risks, alternatives, and next steps. This is particularly relevant when hospitalization, observation, or family involvement is being considered. Patient-centered collaboration does not mean that all decisions can be delegated to the patient when there is imminent danger. It means that even when restrictive measures are necessary, the patient's perspective is heard, the rationale is explained, and autonomy is restored as soon as clinically possible within legal and policy limits.

15. Continuity of Care: From Inpatient Unit to Community:

Continuity of care is a central component of suicide prevention because periods of transition can create gaps in medication, information, therapeutic connection, and access to services. The National Action Alliance for Suicide Prevention's care-transition guidance emphasizes coordinated movement from inpatient to outpatient settings and practical steps to maintain connection and safety during the transition (National Action Alliance for Suicide Prevention, 2019). For psychiatric nurses, discharge planning begins well before the day of discharge. It includes identifying the patient's preferred supports, confirming follow-up arrangements, reviewing the safety plan, assessing practical barriers, and ensuring that important information is communicated to the next provider. The post-discharge period warrants particular attention. Olfson et al. identified substantial short-term suicide risk after psychiatric hospitalization, while Chung et al. described very high pooled rates in the first week and first month, despite heterogeneity between studies (Olfson et al., 2016; Chung et al., 2019). Che et al. subsequently found that earlier outpatient follow-up after psychiatric hospitalization was associated with lower suicide risk in a nationwide Korean cohort, particularly among patients with substance use disorder, schizophrenia, bipolar disorder, and depression (Che et al., 2023). These findings support a nursing focus on timely connection rather than simple "discharge completed" documentation. A safe transition should include a named service or clinician responsible for the next contact, a date and practical method of reaching that service, medication reconciliation, and review of warning signs, crisis resources, and a plan for what to do if the patient cannot attend. Transportation, cost, stigma, caregiver availability, digital access, and geographical distance can all affect follow-up. The nurse should therefore check feasibility, not merely provide an appointment slip. A transition plan is safer when it is realistic, shared, and understood by the patient.



Figure. 4: Continuity of Care Across the Suicide Prevention Transition

16. Early Follow-Up, Caring Contacts, and Treatment Engagement:

Follow-up contact is most useful when it is active, personalized, and linked to the patient's ongoing care. Luxton et al. reviewed follow-up contacts after inpatient or emergency care and concluded that repeated contacts appeared to reduce suicidal behavior in several studies, while also noting the need for stronger evidence about which contact features are most effective (Luxton. et al., 2013). Skopp et al. more recently synthesized caring-contact studies and found mostly protective signals across outcomes, with evidence suggesting benefit for suicide attempts at one year, while uncertainty remained for some suicide mortality and emergency utilization outcomes (Skopp. et al., 2023). The nurse can contribute to caring contacts through telephone calls, messages, outreach visits, or structured follow-up contacts within the organization's scope. The content should be more than "Are you okay?" A useful contact can check current safety, review warning signs, ask whether the patient has used the safety plan, identify barriers to treatment, confirm medication access, and reinforce the patient's next connection to care. When a patient does not respond, a predefined escalation pathway can help prevent silent loss to follow-up.

Evidence from specific populations further demonstrates the potential value of repeated contact. Evidence from follow-up and caring-contact literature supports the broader principle that planned contact after discharge can help maintain connection during a vulnerable period, although the strength of evidence varies by population and intervention (Luxton et al., 2013; Skopp et al., 2023). The psychiatric nurse can make this process more relational by ensuring continuity of the person delivering the contact when feasible.

17. Family and Caregiver Involvement:

Family and caregivers can provide practical support, observation of change, assistance with means restriction, and transport to treatment. However, involvement must be individualized. The patient may not want family involved, family relationships may be unsafe, or privacy and legal considerations may limit information sharing. NICE recommends collaborative discussion about involving family members and carers and recognizes that information needs and preferences may differ (NICE, 2022). The psychiatric nurse should therefore ask the patient who they trust, what they are comfortable sharing, and what support would actually help. When family involvement is appropriate, the nurse can provide education about warning signs, medication storage, follow-up arrangements, and the role of the safety plan. Family members should not be positioned as sole "monitors" of suicide risk. They need clear guidance about when to seek urgent professional help and how to respond without confrontation. A family member can be a support, but the responsibility for clinical assessment remains with health services. This protects both the patient and the caregiver from unrealistic expectations. Family communication should also be strengths-based. The nurse can ask what the patient and family already do well, what has worked during previous crises, and what practical changes are feasible. A family that feels blamed may disengage; a family that feels included in problem solving may become an important continuity resource. Where family relationships are a source of distress, the nurse can coordinate alternative supports such as peer services, community workers, social care, or trusted individuals chosen by the patient.

18. Special Populations and Context-Sensitive Nursing:

Suicide prevention must account for age, developmental stage, culture, communication needs, psychiatric diagnosis, substance use, physical illness, and social context. The ASQ was developed for pediatric emergency

settings, demonstrating the value of concise screening in younger populations (Horowitz et al., 2012). For adolescents, nurses may need to balance confidentiality with safety, work within family and safeguarding frameworks, and assess impulsivity, bullying, school stress, social media influences, and rapid shifts in affect. Adult and older-adult patients may present with different stressors, comorbidities, and access barriers. Psychosis and severe mood disorders require attention to symptom content and behavioral change. For example, command hallucinations, intense guilt, severe hopelessness, mixed mood states, insomnia, or substance intoxication may alter risk even when a patient's verbal description is brief. The nurse should not rely on diagnosis alone; the clinically important question is how symptoms are affecting current judgment, distress, and capacity to use coping strategies. In older adults, physical illness, pain, bereavement, social isolation, and transitions in independence may require special attention. Cultural and contextual humility are equally important. The meaning of suicidal thoughts, family roles, help-seeking, and stigma differs across settings. WHO's suicide-prevention framework highlights the need for actions that consider community and structural context as well as clinical care (World Health Organization, et al., 2021). Psychiatric nurses should use interpreters when necessary, avoid assumptions about beliefs, and ask the patient what support feels acceptable. Patient-centered care is culturally responsive when it is curious rather than prescriptive.

19. Substance Use, Medication Safety, and Medical Contributors:

Alcohol and other substances can increase impulsivity, disinhibition, withdrawal symptoms, and access to risky behavior. The nurse should assess recent use, pattern, intoxication or withdrawal, and the relationship between substance use and suicidal thinking. Acute intoxication can also affect the reliability of self-report; repeated assessment after the patient is more clinically stable may therefore be necessary. WHO guidance supports integrated assessment of suicide and self-harm within broader mental health and substance-use care rather than treating them as separate silos (World Health Organization, et al., 2023). Medication review is another nursing responsibility. Questions may include whether the patient has access to large quantities of medication, whether doses are being taken as prescribed, whether side effects are contributing to nonadherence, and whether recent medication changes coincide with changes in mood or behavior. Nurses should not independently alter prescribed psychiatric treatment outside scope, but they can promptly communicate concerns to prescribers and pharmacists. Medication reconciliation during transition is particularly important because discontinuity can destabilize symptoms or create confusion about the treatment plan. Physical health also matters. Pain, sleep disturbance, neurological conditions, endocrine disorders, medication effects, and other medical contributors can influence mood and distress. The psychiatric nurse should remain alert to signs that require medical review. A patient-centered risk assessment therefore extends beyond the psychiatric symptom list. The person's physical discomfort, nutrition, sleep, mobility, and ability to manage daily needs can affect coping capacity and willingness to engage with treatment.

20. Education, Competence, and Professional Development:

Suicide-prevention competence requires ongoing education rather than a one-time orientation. Ferguson et al. reviewed nurse-focused education programs and found short-term improvements in knowledge, competence, and attitudes, while noting that program heterogeneity and methodological weaknesses limited conclusions about long-term practice change (Ferguson, et al., 2018). Woods et al. reported improved suicide-related knowledge and attitudes after a brief web-based educational module for psychiatric-mental health nurses, again supporting the value of structured learning (Woods, et al., 2024). Training should include more than screening questions. Nurses need practice in direct inquiry, risk formulation, therapeutic communication, de-escalation, safety planning, means-safety counseling, documentation, family engagement, and care transitions. Simulation and case-based learning can help staff recognize subtle changes and rehearse difficult conversations. Education should also address the emotional impact of caring for suicidal patients, because fear and uncertainty can affect practice. Supervision and reflective discussion allow nurses to examine their responses without shame and develop more consistent therapeutic strategies. Competence should be evaluated in practice. Organizations can observe whether staff can demonstrate direct questioning, explain the purpose of safety planning, complete clear documentation, and communicate escalation concerns. Riedel et al. argue that nurses' suicide-prevention contributions require organizational support and formal recognition as well as individual competence (Riedel, et al., 2025). Training is therefore a system intervention. If staffing levels, documentation burden, and access to senior support make safe practice difficult, education alone will not solve the problem.

21. Ethical and Legal Dimensions of Nursing Practice:

Suicide-related care creates an ethical tension between respect for autonomy and the duty to protect life when there is imminent danger. Psychiatric nurses must work within local laws, professional standards, mental health

legislation, consent requirements, safeguarding duties, and organizational policy. Ethical practice requires the nurse to explain actions where possible, seek the patient's participation, use the least restrictive safe approach, and document the reasoning behind important decisions. Because legal frameworks vary, this article does not substitute for local legal guidance. Confidentiality also requires careful handling. Patients should understand what information can remain private and under what circumstances information may need to be shared for safety. When family or caregivers are involved, the nurse should disclose only what is appropriate within law and policy. The guiding principle is to protect safety while preserving as much privacy and therapeutic trust as possible. Where uncertainty exists, the nurse should seek supervision or senior clinical guidance rather than making a high-stakes decision in isolation. Ethical patient-centered care includes respect for dignity after an attempt or episode of self-harm. Patients may feel shame, anger, embarrassment, or fear of judgment. Staff language matters. The person should not be reduced to an event, a diagnosis, or a risk label. The nurse can acknowledge what happened while also emphasizing recovery, capacity for change, and the next practical step in care. This approach supports engagement and can make future disclosure more likely.

22. Quality Improvement and Organizational Safety:

Reducing suicide risk depends on reliable systems as well as individual clinicians. The Joint Commission's suicide risk-reduction framework includes screening, evidence-based assessment, documentation, environmental risk reduction, staff training, reassessment, monitoring, discharge follow-up, and review of program effectiveness (The Joint Commission, et al., 2026). Organizations can translate these principles into measurable processes such as timely assessment after a positive screen, completion of collaborative safety plans, documented means-safety counseling, successful handover, follow-up appointment confirmation, and documented post-discharge contact. Quality indicators should not become box-ticking exercises. A safety plan recorded in the electronic health record is not necessarily a meaningful plan if the patient cannot explain it or if the plan ignores practical barriers. Similarly, an appointment scheduled for the patient is not true continuity if transportation is impossible. Audits should therefore include qualitative review of documentation, patient experience, and failed transitions. Data from incidents and near misses can identify system weaknesses without turning every adverse event into an individual blame exercise. Organizations should also examine workforce factors. Riedel et al. and Ferguson et al. point to the importance of organizational support, training, and role clarity in enabling nurses to contribute effectively to suicide prevention (Riedel, et al., 2025; Ferguson et al., 2018). Although workforce suicide and patient suicide are distinct problems, both remind institutions that staff cannot provide consistently therapeutic care when systems leave them isolated, overstretched, or unsupported. Reflective supervision, access to consultation, and protected educational time are practical components of a safe mental health service.

23. Digital Health and Telehealth in Continuity of Care:

Digital communication can extend suicide-prevention support beyond the walls of the hospital. Telephone follow-up, secure messaging, video appointments, and digital reminders can help patients reconnect quickly when travel or service capacity is limited. Luxton et al. included technology-based follow-up methods in their review, while Skopp et al. synthesized caring-contact approaches across multiple systems (Luxton et al., 2013; Skopp et al., 2023). The value of technology lies less in the medium itself than in whether the contact is timely, relational, and connected to ongoing care. Nurses may use telehealth to reassess current safety, review the safety plan, identify missed appointments, explore changes in stress or symptoms, and activate escalation procedures. Digital contact can also support continuity when the same nurse follows the patient across settings. However, telehealth is not universally appropriate. Privacy, connectivity, digital literacy, language, cognitive capacity, and access to a safe location all matter. A patient in a private space may engage differently from a patient sharing a phone in a crowded household. Technology also creates new documentation and communication questions. Messages may be missed, delayed, or sent outside working hours. Organizations should define who monitors digital channels, expected response times, emergency instructions, and escalation pathways. Technology should not create the false impression that availability is unlimited. A patient-centered model clearly explains what the service can provide and what to do in an emergency. Used within a well-designed system, digital tools can reinforce rather than replace human connection.

24. Common Challenges in Psychiatric Nursing Practice:

Time pressure is a major challenge. Detailed psychosocial assessment, therapeutic engagement, medication care, observation, documentation, and coordination all require time. Curran et al. identified administrative workload as a significant barrier to therapeutic nurse-patient relationships, even when nurses recognized the value of collaboration (Riedel, et al., 2025). Organizations therefore need to consider workflow design when

asking nurses to implement additional suicide-prevention processes. A measure that adds paperwork without improving clinical communication can increase burden without increasing safety. Another challenge is uncertainty. Nurses may fear that a patient will die by suicide despite appropriate care, leading to defensive over-monitoring or excessive restrictions. Conversely, repeated exposure to suicidal behavior can create frustration or desensitization. Neither response is ideal. Reflective practice, supervision, clear escalation pathways, and team-based decision making can help clinicians remain attentive without becoming either punitive or paralyzed. The purpose of formulation is not to eliminate uncertainty; it is to make reasoning transparent and guide proportionate action. Fragmentation across services is a further barrier. Patients may move between emergency departments, psychiatric units, primary care, addiction services, and community programs, with each setting using different terminology and documentation systems. National and local care-transition guidance emphasizes coordination, but implementation often depends on practical relationships between professionals (National Action Alliance for Suicide Prevention, 2019). Psychiatric nurses can help bridge these gaps by transmitting clinically meaningful information, confirming next contacts, and ensuring that the patient's own goals and safety plan travel with the record.

25. Future Directions for Psychiatric Nursing:

Future suicide-prevention nursing research should move beyond questions of whether nurses are involved and toward questions of which nursing actions produce meaningful patient outcomes, in which settings, for whom, and under what conditions. Riedel et al. identified the need for implementation research across cultural and healthcare contexts, while Ferguson et al. and Woods et al. demonstrate both the promise and the limitations of current nurse education evidence (Riedel et al., 2025; Ferguson et al., 2018; Woods et al., 2024). Research should examine patient-reported outcomes such as perceived safety, trust, treatment engagement, confidence in the safety plan, and continuity of relationships, alongside traditional clinical outcomes. There is also a need to improve the design of transition systems. Che et al. suggest that earlier follow-up is associated with lower suicide risk after psychiatric discharge, while Hanrahan et al. showed that a nurse-led transitional care model could improve continuity-related outcomes but may require multidisciplinary adaptation for people with serious mental illness (Che et al., 2023; Hanrahan et al., 2014). Future models should therefore combine the relational strengths of nursing with coordinated medical, psychological, social, and peer support. Patient involvement should remain central. People with lived experience can help design safety-plan language, discharge processes, ward environments, follow-up pathways, and staff education. The most effective prevention systems may be those that treat patients as partners in service design rather than passive recipients of risk management. Psychiatric nursing can contribute to this shift by bringing everyday patient experience into quality improvement, education, and clinical governance.

26. Practical Patient-Centered Nursing Framework:

A practical framework can bring the review together in a sequence that remains flexible across settings. First, establish connection and immediate physical and psychological safety. Second, ask directly about suicidal thoughts and behaviors and determine whether a fuller assessment is required. Third, assess dynamic drivers, protective factors, and access to means, mental state, substance use, physical contributors, and social context. Fourth, formulate the situation collaboratively with the patient and team, identifying what is most changeable now. Fifth, implement proportionate interventions such as observation, environmental precautions, urgent psychiatric review, means restriction, treatment of acute medical or psychiatric contributors, and safety planning. The next steps are equally important. The nurse should document the formulation and plan clearly, communicate changes across the team, involve chosen supports where appropriate, and prepare for transition before discharge. The patient should leave with a safety plan that they understand, practical access to treatment, known points of contact, and a realistic follow-up arrangement. Early contact should reassess safety rather than merely confirm attendance. Long-term continuity should focus on treatment engagement, recovery goals, coping skills, and the patient's own priorities. This framework reflects the current direction of guidance: from prediction toward formulation, from isolated tasks toward coordinated care, and from surveillance alone toward therapeutic safety. The framework also supports reflective nursing practice. After a crisis or near miss, the nurse can ask what was noticed early, what information was available, which protective factors were strengthened, where communication failed, and what the patient experienced as helpful or harmful. These questions support learning without reducing suicide prevention to retrospective blame. In patient-centered care, the quality of the therapeutic relationship is itself an outcome worth examining. A patient who feels safe enough to disclose escalating suicidal thoughts may present earlier, engage more consistently, and have more opportunities for intervention.

27. Patient-Centered Suicide Risk Interview and Shared Understanding:

A patient-centered suicide risk interview begins with the quality of the encounter rather than the number of questions completed. The psychiatric nurse establishes privacy, introduces the purpose of the conversation, and explains that direct questions about suicide are intended to understand the patient's experience and support safety. This opening matters because many patients anticipate judgment, loss of control, or involuntary consequences. A calm explanation can make disclosure more acceptable while allowing the nurse to remain clinically clear. The conversation should proceed at a pace that permits the patient to describe what has been happening in their own words, with the nurse clarifying the timing, intensity, frequency, and change in suicidal thoughts or behaviors (Turecki, et al., 2019; NICE, 2022). The nurse should distinguish between a screening exchange and a full clinical assessment. A brief screen may identify that additional assessment is indicated, but it does not by itself establish the meaning, context, or current level of concern. NICE recommends a psychosocial assessment that explores the factors contributing to self-harm or suicidal behavior and supports a shared understanding of needs rather than relying on a global risk category (NICE, 2022). This approach is particularly important when patients have fluctuating thoughts, difficulty communicating, altered mental status, or concerns about what may happen if they answer honestly. The interview should explore the patient's perspective on what makes the current situation harder and what has previously helped. Questions about reasons for living, valued relationships, responsibilities, coping strategies, treatment preferences, and practical barriers can identify protective resources that are available immediately. Protective factors should not be documented as static guarantees of safety. Their usefulness depends on whether they are accessible, meaningful, and strong enough to influence behavior during periods of crisis. The nurse therefore asks how a patient can actually use a protective factor, not simply whether one exists (Turecki, et al., 2019). Shared understanding is strengthened when the nurse reflects back the information and checks accuracy. For example, the nurse may summarize that suicidal thoughts have intensified after a recent stressor, that the patient has not acted on a current plan, that sleep and substance use have changed, and that a trusted family member is willing to help. The patient can then correct, add, or disagree with the formulation. This collaborative process turns assessment from an interrogation into a clinical dialogue and improves the likelihood that the care plan reflects the patient's actual experience. The nurse should document important patient words alongside professional interpretation so that later clinicians can understand both the lived experience and the clinical reasoning.

28. Nursing Actions during the First 24 Hours of Acute Risk:

The first hours after presentation or recognition of acute suicide risk require coordinated nursing action. Immediate priorities include maintaining physical safety, completing or contributing to an appropriate assessment, identifying changes in mental state, reviewing environmental risks, and ensuring that urgent medical or psychiatric review occurs when indicated. The nurse continuously observes for agitation, intoxication, severe anxiety, psychosis, confusion, withdrawal, sudden behavioral change, and other factors that may alter the clinical picture. The Joint Commission emphasizes an integrated approach that includes screening, evidence-based assessment, environmental risk reduction, staff competence, reassessment, and monitoring (The Joint Commission, et al., 2026). Observation should be purposeful rather than automatic. When increased observation is required, the nurse explains what the patient can expect, maintains respectful interaction, and reviews the need for the level of observation as the clinical situation changes. The purpose is not simply to prevent a person from moving or being alone; it is to reduce opportunity for immediate self-harm while preserving therapeutic connection. Staff should communicate observation changes clearly during handovers because inconsistency can confuse patients and create gaps in safety. Riedel et al. describe nursing roles in risk management as including ongoing monitoring, communication, and coordinated preventive action (Riedel, et al., 2025). Medication and physical health considerations also belong in the first-day plan. Nurses administer prescribed medication safely, observe for adverse effects, assess whether substances or withdrawal may be affecting behavior, and report acute medical concerns. A patient may present with psychological distress while also experiencing pain, sleep deprivation, intoxication, withdrawal, delirium, or another physical contributor. The nursing assessment therefore remains holistic. The aim is not to assume that every behavioral change is psychiatric but to identify the whole clinical situation so that appropriate treatment can begin. The first 24 hours are also an opportunity to begin recovery-oriented care. Even when immediate restrictions are necessary, the nurse can ask what would make the patient feel safer, who they would like involved, what has helped during previous crises, and what they are willing to work on today. Small collaborative decisions can restore a sense of agency at a time when the patient may feel that many decisions are being made about them. The combination of immediate safety and respectful participation is central to patient-centered psychiatric nursing.

29. Discharge Readiness and Transition Preparation:

Discharge planning for a patient with recent suicidal thoughts, self-harm, or suicide attempt should begin early rather than at the end of the admission. The National Action Alliance for Suicide Prevention describes care transition as a period in which communication, follow-up, and continuity should be deliberately organized rather than assumed (National Action Alliance for Suicide Prevention, et al., 2019). The psychiatric nurse can begin by identifying the patient's likely destination, existing mental health providers, medication supply, transportation needs, family or chosen support, communication preferences, and barriers that could interfere with follow-up. A patient-centered discharge plan should translate clinical recommendations into practical actions. Telling a patient to "follow up with mental health services" is less useful than identifying who will contact them, when the appointment will occur, how they will travel, what to do if symptoms worsen, and which service can be reached outside routine hours. The nurse can review the safety plan with the patient and confirm that the warning signs, coping strategies, support contacts, professional resources, and means-safety steps are understandable and realistic. Safety planning has a growing evidence base, but its effectiveness depends on meaningful collaborative use rather than documentation alone (Stanley, et al., 2018; Nuij, et al., 2021). The transition conversation should also prepare the patient for variability after discharge. Sleep may change, stressors may return, appointments may feel overwhelming, and suicidal thoughts may fluctuate. The nurse can help the patient identify early signs that should prompt contact with the treatment team and agree on practical steps that can be taken before a crisis escalates. This is not a substitute for emergency care when immediate danger is present; rather, it creates a graded plan for responding to changes in distress. Clear escalation instructions should be written in language the patient can understand and should reflect local services and emergency pathways.

Family or chosen supports may need their own transition information. With appropriate consent and within legal and organizational requirements, they can receive guidance on the safety plan, signs that concern should increase, who to contact, and how to support means safety without turning the home into a surveillance setting. The nurse can also ask the patient what kind of support feels helpful and what kinds of communication increase distress. This protects the patient's voice during a transition when family involvement may be essential but must still remain respectful and collaborative.

30. Continuity Handover and Follow-Up Troubleshooting:

A successful handover is more than sending a discharge summary. It is the transfer of clinically meaningful knowledge between people and services. The receiving clinician should understand recent suicidal behavior or thoughts, current formulation, changes during admission, important protective factors, treatment decisions, medication issues, safety-plan content, and outstanding concerns. The sending nurse should also confirm the next point of contact and communicate any barriers that could cause the plan to fail. Care transitions are safer when responsibility is explicit rather than assumed (National Action Alliance for Suicide Prevention, 2019).

The nurse can use follow-up contacts to test whether the transition actually worked. The first contact should reassess the current situation, not simply ask whether the patient attended an appointment. Questions may explore whether suicidal thoughts have changed, whether the safety plan is accessible, whether medications were obtained, whether the patient understands the next appointment, and whether any new stressor has emerged. Evidence from post-discharge contact reviews supports continued engagement after hospitalization, although the type, frequency, and delivery method of follow-up vary across studies and settings (Luxton et al., 2013; Skopp et al., 2023). Troubleshooting is an important nursing skill. A patient may miss an appointment because transportation failed, a clinic did not call, a prescription was unavailable, or anxiety made attendance difficult. The nurse can treat these events as continuity problems that require problem solving rather than as evidence that the patient is simply non-compliant. Depending on local scope and service design, nursing staff may help reschedule appointments, communicate with the receiving service, clarify medication questions, involve supports with consent, or escalate new risk. The purpose is to reduce friction at the point where vulnerable patients are most likely to disengage. Early follow-up deserves particular attention because psychiatric discharge can be a period of heightened vulnerability. Studies have identified elevated suicide risk soon after hospitalization, and more recent observational work suggests that the timing of follow-up is associated with subsequent outcomes (Olfson et al., 2016; Chung et al., 2019; Che et al., 2023). These findings do not mean that a single scheduled visit prevents suicide. They support the practical principle that contact should occur promptly and that patients should not be left without a clear bridge between inpatient and community care.

31. Family Engagement, Communication, and Respect for Patient Choice:

Family and caregivers can provide important knowledge about changes in behavior, access to means, daily functioning, and early warning signs. They can also help with transportation, medication routines, appointments, and emotional support. Patient-centered practice requires that this involvement be negotiated rather than assumed. The nurse should ask whom the patient trusts, what information they are comfortable sharing, and what role they want a family member or chosen support to play. When safety-related information must be shared under applicable law or policy, the nurse should communicate transparently where possible and continue to preserve dignity. Family communication should avoid turning relatives into informal security staff. The aim is to build a support network that recognizes warning signs while preserving ordinary relationships and recovery goals. Caregivers may need education about reducing access to lethal means, responding calmly to escalating distress, using the patient's preferred coping strategies, and contacting professional services when the agreed plan is no longer sufficient. Lethal means counseling has been described as an important component of suicide prevention, particularly when it is practical and collaborative rather than judgmental (Runyan et al., 2018; Hunter et al., 2021).

The nurse should also remain attentive to situations in which family involvement is not safe or desired. Conflict, abuse, coercion, stigma, or family burnout may limit the usefulness of a particular support person. A patient may prefer a friend, peer, community worker, or another trusted person. The principle is to strengthen the patient's support system according to their circumstances, not to force a standard family model. This is especially important for people whose living arrangements, culture, age, or social context differ from the assumptions built into routine discharge processes. Family education should include recovery language as well as risk information. Relatives need to know that improvement can be gradual and that the goal is not to remove every source of distress. The nurse can encourage communication that acknowledges the patient's feelings without reinforcing hopelessness, and can explain when urgent professional assessment is needed. This approach can reduce fear and help families act as partners in continuity of care rather than as observers waiting for a crisis.

32. Measuring Patient-Centered Outcomes in Suicide Prevention Nursing:

Clinical services often measure suicide prevention through process indicators such as completed assessments, observation documentation, referrals, and follow-up appointments. These measures are useful, but they do not fully capture whether care was experienced as therapeutic or whether the patient can use the plan after discharge. Patient-centered evaluation should include outcomes such as perceived safety, trust in staff, understanding of the safety plan, confidence in accessing help, continuity with a known clinician, and ability to identify practical next steps. Such outcomes are consistent with a broader nursing role that combines risk management with therapeutic relationship and coordination (Riedel, et al., 2025). Patient feedback can be collected through structured questions, interviews, or service-user involvement in quality improvement. A patient might report that a safety plan was technically completed but did not reflect their real environment, that repeated questioning felt judgmental, or that the discharge plan was confusing. These comments are clinically relevant because they identify barriers that may not appear in administrative data. They can also show where nurses and patients understand the same encounter differently. Incorporating lived experience into quality improvement therefore strengthens both safety and relevance. Organizations should interpret outcome data carefully. Suicide is a relatively rare outcome compared with the large number of people who experience suicidal thoughts or self-harm, making it difficult for any single intervention or nursing service to demonstrate effects through crude event counts alone. Process measures, patient-reported measures, continuity indicators, and case review can provide complementary information. Evidence on prediction also cautions against treating a risk score as if it were a reliable forecast of individual behavior (Franklin et al., 2017; Carter et al., 2017). For psychiatric nurses, a balanced evaluation framework asks three questions: Was the patient safer during the episode of care? Did the patient understand and participate in the plan? Did the service create a workable bridge to the next stage of care? This framing supports clinical learning while avoiding the assumption that prevention can be reduced to one number. It also aligns with the practical reality that nursing influence extends across assessment, crisis intervention, therapeutic engagement, environmental safety, education, coordination, and follow-up.

33. Practice Integration Across Clinical Care Settings:

The psychiatric nurse's suicide-prevention role changes with the setting, but the underlying principles remain consistent. In emergency care, the emphasis is on rapid recognition, immediate safety, focused assessment, and coordination with medical and psychiatric teams. In an inpatient psychiatric unit, the nurse has greater opportunity for repeated observation, therapeutic engagement, collaborative safety planning, medication

education, and preparation for discharge. In community care, the emphasis shifts toward continuity, relapse prevention, monitoring of changes, practical problem solving, and maintaining connection with treatment and social supports. The same patient-centered formulation should travel across these settings so that the meaning of risk is not reconstructed from scratch at every transition (National Action Alliance for Suicide Prevention, 2019; Riedel et al., 2025). Primary care and community mental health services may encounter patients whose suicidal distress is less visible because the visit is focused on another problem. Psychiatric nurses working in these settings can contribute through attentive listening, direct inquiry when clinically indicated, coordination with specialist services, and follow-up of patients whose needs cross service boundaries. WHO guidance emphasizes integrated and coordinated approaches to suicide prevention rather than dependence on a single profession or isolated intervention (World Health Organization, 2021; World Health Organization, 2023). This supports a nursing role that includes helping patients move between levels of care without losing access to the therapeutic relationship. In emergency and inpatient environments, nurses may also be responsible for balancing competing priorities. A patient may need treatment for intoxication, injury, severe agitation, or another urgent medical problem while also requiring suicide-focused assessment. Safe care depends on integrating these needs rather than separating physical and psychological concerns. Once immediate medical stabilization has occurred, the psychiatric nurse can return to the broader formulation and identify factors that require attention before transfer or discharge. This sequencing helps prevent the common problem of treating the crisis event while leaving the conditions that contributed to it insufficiently addressed (Turecki et al., 2019; NICE, 2022). Across all settings, continuity is improved when the patient knows what will happen next. The nurse can explain who will receive the handover, when follow-up should occur, what to do if distress increases, and which parts of the plan are flexible. A patient-centered system also recognizes that engagement can change after discharge. Missed contact, ambivalence about treatment, or difficulty carrying out a safety plan should prompt curiosity and practical problem solving rather than automatic labeling. The overall aim is to maintain a reliable bridge between the patient's immediate experience and the next opportunity for therapeutic care (Luxton et al., 2013; Che et al., 2023; Skopp et al., 2023).

34. Reflection, Debriefing, and Learning After a Suicide-Related Crisis:

After a suicide attempt, serious episode of suicidal distress, or unexpected escalation of risk, psychiatric nurses may need structured opportunities to review what occurred. Clinical debriefing should focus on the patient's experience, the sequence of events, communication, environmental factors, and points at which care could be strengthened. It should avoid simplistic blame because suicide-related outcomes are influenced by multiple interacting factors. Review is most useful when it produces practical learning that can improve assessment, observation, safety planning, documentation, and transition processes (Riedel et al., 2025). Patient involvement can add information that is unavailable in the clinical record. With appropriate safeguards, the service can ask what the patient experienced as helpful, what increased distress, whether staff listened to their concerns, and whether the safety plan reflected their circumstances. These perspectives can reveal differences between what clinicians intended and what the patient actually experienced. Patient-centered quality improvement therefore treats lived experience as meaningful evidence for service development rather than as an optional satisfaction measure.

Nurses also benefit from professional reflection after difficult events. Education reviews have shown that suicide-prevention competence involves knowledge, attitudes, and confidence, while organizational support influences whether learning can be translated into practice (Ferguson et al., 2018; Woods et al., 2024). Reflective supervision can help nurses examine fear, uncertainty, frustration, or emotional attachment without allowing those reactions to determine clinical decisions. The purpose is to sustain compassionate vigilance and strengthen future therapeutic encounters. Learning should be fed back into the system. A review may identify the need for clearer escalation pathways, improved handover, more accessible safety-plan templates, environmental changes, additional training, or stronger follow-up arrangements. In this way, a single clinical episode becomes a source of organizational learning. Suicide prevention is strengthened when services repeatedly examine how assessment, crisis intervention, and continuity of care connect in real practice rather than treating each element as a separate task (The Joint Commission, 2026; National Action Alliance for Suicide Prevention, 2019).

35. Conclusion:

Psychiatric nurses occupy a pivotal position in suicide prevention because their practice spans observation, assessment, therapeutic engagement, crisis response, inpatient safety, education, coordination, and continuity of care. The evidence reviewed in this article supports a model in which suicide risk is understood as dynamic and contextual rather than reduced to a score or a global label. Current guidance recommends direct inquiry,

psychosocial assessment, clinical formulation, collaborative safety planning, environmental and means-safety interventions, and careful transition planning (NICE, 2022; World Health Organization, 2023; The Joint Commission, 2026). The period after psychiatric discharge deserves particular nursing attention. Evidence indicates heightened short-term risk and suggests that early outpatient contact, repeated follow-up, and caring contacts can support safety and engagement, although not every intervention has identical evidence across populations (Olfson et al., 2016; Chung et al., 2019; Che et al., 2023; Skopp et al., 2023). The nurse's contribution is therefore not limited to what happens on the ward. It extends to preparing the patient and family for the next setting, communicating meaningful information, checking whether follow-up is feasible, and maintaining therapeutic connection through vulnerable transitions. Ultimately, patient-centered suicide prevention is relational, collaborative, and continuous. It combines clinical vigilance with respect for autonomy, practical action with empathy, and immediate safety with recovery-oriented goals. Psychiatric nurses can strengthen this model when organizations invest in training, staffing, supervision, coordinated documentation, environmental safety, and systems that make continuity possible. The most reliable prevention approach is not a single tool or intervention but a connected system in which the patient is seen, heard, involved, and supported across the full course of care.

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