



Building an Evidence-Based Nursing Protocol for Suicide Risk Identification and Early Intervention in Non-Psychiatric Healthcare Settings

Alexandros Argyriadis¹¹ *PhD, Hellenic Mediterranean University, Heraklion, Greece.*

Article Info

Article History:*Published: 30 Jan 2026***Publication Issue:***Volume 3, Issue 01
January-2026***Page Number:***619-627***Corresponding Author:***Alexandros Argyriadis****Abstract:***

Suicide constitutes a major global public health concern, with increasing incidence across diverse populations and healthcare contexts. Nurses often represent the first point of contact for individuals experiencing suicidal ideation, particularly in non-psychiatric settings such as primary care, emergency departments, and community health services. Despite this critical role, nursing practice related to suicide risk identification and early intervention frequently remains fragmented, experience-based, and insufficiently supported by structured protocols. The present article aims to develop and theoretically substantiate an evidence-based nursing protocol for suicide risk identification and early intervention applicable to non-psychiatric healthcare settings. Drawing on contemporary evidence from mental health nursing, public health, and implementation science, the article outlines the conceptual foundations, methodological steps, and clinical logic underpinning protocol construction. Emphasis is placed on early recognition of risk indicators, structured nursing assessment, therapeutic communication, escalation pathways, and interprofessional collaboration. The proposed protocol seeks to enhance consistency, safety, and clinical confidence in nursing practice, while supporting a proactive, preventive approach to suicide within routine healthcare environments. This work contributes to the advancement of evidence-based nursing practice by translating research evidence into actionable, context-sensitive clinical guidance.

Keywords: suicide prevention, evidence-based nursing, nursing protocols, mental health nursing, early intervention

1. Introduction

Suicide remains one of the most pressing and multifaceted challenges in global public health, accounting for more than 700,000 deaths annually worldwide and exerting profound psychological, social, and economic consequences on individuals, families, and communities (World Health Organization [WHO], 2023). Beyond mortality, suicidal behavior is associated with long-term trauma among survivors, increased healthcare utilization, and substantial societal costs. Epidemiological evidence indicates that suicide rates have remained persistently high or have increased in many regions, particularly among adolescents, young adults, and populations exposed to cumulative social, economic, and psychological stressors, including unemployment, social isolation, and chronic illness (Turecki et al., 2019; Hawton & Williams, 2021).

Importantly, suicidal behavior is not restricted to individuals receiving psychiatric care or to specialized mental health services. A growing body of research demonstrates that many individuals who die by suicide have had recent contact with non-psychiatric healthcare services, such as primary care, emergency departments, outpatient clinics, or community health structures, often within weeks or months prior to death (Luoma et al., 2002; Stene-Larsen & Reneflot, 2017). In these encounters, individuals frequently present with somatic complaints, sleep disturbances, chronic pain, or nonspecific psychological distress rather than explicit expressions of suicidal ideation. As a result, opportunities for early identification and prevention may be missed when suicide risk is not systematically assessed within routine healthcare interactions.

Within these non-psychiatric settings, nurses occupy a pivotal and often underrecognized role in suicide prevention. As frontline healthcare professionals, nurses maintain continuous and sustained contact with patients, engage in holistic assessment, and establish therapeutic relationships that extend beyond episodic medical encounters. This positioning enables nurses to detect subtle behavioral changes, emotional cues, and contextual stressors that may signal elevated suicide risk (Bolster et al., 2015). However, despite their central role, nursing practice related to suicide prevention remains inconsistent and highly variable across settings. Studies consistently report that many nurses experience uncertainty, limited confidence, and emotional discomfort when addressing suicidal ideation, particularly in environments not explicitly designated for mental health care (Bohanna & Wang, 2012; Saunders et al., 2014).

A critical contributor to this variability is the limited availability of structured, nursing-specific guidance for suicide risk identification and early intervention. While numerous screening tools, risk assessment instruments, and clinical guidelines exist, these resources are often designed for psychiatric professionals, rely on diagnostic frameworks beyond the nursing scope of practice, or require institutional infrastructures that are not readily accessible in general healthcare environments (O'Connor & Portzky, 2018). Consequently, nurses frequently rely on individual clinical judgment, informal practices, or ad hoc decision-making processes, which may increase the risk of delayed intervention or inconsistent care.

The absence of standardized, evidence-based nursing protocols for suicide prevention contributes to fragmented practice, reduced clinical confidence, and missed preventive opportunities. From a systems perspective, this gap also undermines interprofessional collaboration, as unclear nursing roles and pathways may delay referral, escalation, or continuity of care. Addressing suicide prevention therefore requires not only increased awareness but also the translation of research evidence into practical, context-sensitive nursing guidance that can be applied across diverse healthcare settings.

Evidence-based practice (EBP) provides a robust and ethically grounded framework for addressing this challenge. EBP emphasizes the integration of the best available research evidence with clinical expertise and contextual factors, supporting the development of standardized yet adaptable clinical protocols (Melnyk & Fineout-Overholt, 2019). In the context of suicide prevention, evidence-based nursing protocols have the potential to enhance early detection of risk, promote therapeutic engagement, clarify clinical decision-making, and support timely referral and interprofessional collaboration (Zalsman et al., 2016). Importantly, such protocols can empower nurses to act proactively within their professional scope, reinforcing suicide prevention as a core component of routine nursing care rather than a specialized or exceptional task.

The purpose of this article is to present the conceptual and methodological foundations for constructing an evidence-based nursing protocol focused on suicide risk identification and early intervention in non-psychiatric healthcare settings. Rather than evaluating clinical outcomes, the article emphasizes protocol development as a critical and often overlooked step in strengthening preventive nursing practice. By articulating core components, clinical logic, and implementation considerations grounded in contemporary evidence, this work aims to support nurses, educators, and healthcare organizations in operationalizing suicide prevention as an integral, systematic, and evidence-informed element of everyday nursing care.

2. Methodological Approach to Protocol Development

Conceptual Framework

The proposed protocol is grounded in a biopsychosocial understanding of suicidal behavior, recognizing suicide risk as a dynamic process influenced by individual vulnerability, psychosocial stressors, and environmental factors. From a nursing perspective, this framework aligns with holistic care models that emphasize person-centered assessment, relational engagement, and contextual awareness.

Central to the protocol is the assumption that suicide risk exists along a continuum rather than as a dichotomous state. Early indicators such as hopelessness, emotional withdrawal, sleep disturbance, and expressions of burden may precede overt suicidal ideation. Nurses, through sustained patient interaction, are well positioned to identify these early warning signs and initiate preventive actions before crisis escalation occurs.

The protocol also draws on principles of therapeutic communication and trauma-informed care. Establishing a nonjudgmental, empathetic, and supportive nurse–patient relationship is essential for facilitating disclosure of distress and suicidal thoughts. Evidence suggests that direct, compassionate inquiry about suicide does not increase risk and may, in fact, reduce feelings of isolation and ambivalence.

The construction of the evidence-based nursing protocol followed a structured methodological process informed by evidence synthesis and practice translation principles. Initially, contemporary research literature addressing suicide risk factors, nursing assessment, early intervention strategies, and healthcare-based prevention models was systematically reviewed. Emphasis was placed on evidence applicable to non-psychiatric settings and general nursing roles.

Synthesized evidence was then translated into operational nursing actions, ensuring alignment with nursing scope of practice, feasibility in routine care, and clarity of decision-making. This translation process focused on defining observable indicators, structured assessment questions, communication strategies, and escalation criteria.

The protocol was organized into sequential phases encompassing risk recognition, nursing assessment, therapeutic response, safety planning, and referral pathways. Each phase was designed to guide nurses through clear, actionable steps while allowing flexibility based on contextual factors and available resources.

Core Components of the Evidence-Based Nursing Protocol

The protocol emphasizes early identification of suicide risk through systematic observation and inquiry. Nurses are guided to attend to behavioral, emotional, and contextual indicators that may signal distress, even in the absence of explicit suicidal statements. Structured assessment supports consistent documentation and clinical reasoning.

Therapeutic communication constitutes a central component, with guidance on how to engage patients in open dialogue about distress and suicidal thoughts using clear, compassionate language. The protocol highlights the importance of validating emotional experiences while avoiding minimization or alarmist responses.

Clear escalation pathways are embedded within the protocol to support timely referral and interprofessional collaboration. Nurses are provided with criteria for determining when immediate intervention is required and how to activate appropriate support systems within their organizational context.

Implications for Nursing Practice and Education

The development of an evidence-based nursing protocol for suicide prevention has significant implications for clinical practice, education, and healthcare policy. Standardized guidance can enhance nurse confidence, reduce variability in care, and support safer clinical environments. In educational contexts, the protocol can serve as a teaching tool for undergraduate and continuing professional development programs, bridging the gap between theory and practice.

3. Results

The protocol development process yielded a finalized evidence-based nursing protocol for suicide risk identification and early intervention designed for non-psychiatric healthcare settings. The results are presented as the concrete outputs of the protocol construction workflow, including the finalized protocol architecture, decision logic, operational definitions, risk stratification structure, action pathways, documentation templates, and implementation supports. No human participants or patient-level data were used at any stage of protocol development; accordingly, no clinical outcome results are reported.

The finalized protocol was structured into five sequential and interlinked modules that correspond to typical nursing workflow in non-psychiatric settings. First, a Recognition and Trigger module defined observable indicators and contextual cues that initiate protocol activation, including affective signals, behavioral changes, verbal content suggestive of hopelessness or burdensomeness, sudden agitation, withdrawal, and clinical-context risk markers (e.g., recent loss, acute intoxication, severe insomnia). Second, a Structured Nursing Assessment module operationalized a brief, standardized sequence of assessment prompts and safety checks intended to be feasible during routine nursing encounters. Third, a Therapeutic Response module specified immediate communication practices to support disclosure, reduce distress, and maintain engagement. Fourth, a Safety and Escalation module provided structured risk stratification and corresponding escalation pathways, including urgent response procedures for imminent risk. Fifth, a Continuity and Referral module standardized next-step planning, referral routing, documentation expectations, and follow-up actions across settings.

Each module was designed to function both independently and as part of an integrated pathway, enabling nurses to enter the protocol at different points depending on the clinical situation while preserving logical continuity across steps.

A set of explicit activation triggers was produced to guide nurses in initiating the protocol without reliance on subjective thresholds alone. Triggers were defined at three levels. Level A triggers reflected direct suicidal communications, such as statements indicating intent, plan, desire to die, or self-harm planning. Level B triggers reflected indirect signals, including hopelessness, perceived burdensomeness, social withdrawal, escalating agitation, or sudden calm after distress. Level C triggers reflected contextual and clinical risk conditions commonly encountered in non-psychiatric settings, such as recent major loss, interpersonal violence exposure, acute substance intoxication or withdrawal, severe pain, diagnosis disclosure, or recent discharge from any care setting. The protocol allowed activation via any trigger level, with assessment depth and escalation intensity determined by subsequent stratification steps.

The protocol produced a standardized nursing assessment sequence designed to be completed within a brief, clinically realistic timeframe. The sequence included (a) direct inquiry about suicidal thoughts using clear language, (b) a check for intent and planning, (c) assessment of means access and immediacy, (d) brief evaluation of protective factors and willingness to accept help, and (e) identification of acute destabilizers such as intoxication, severe agitation, psychotic-like experiences, or inability to guarantee safety. The assessment outputs were converted into operational categories that directly link to the action pathways described below. The assessment was intentionally designed to be descriptive and action-oriented, emphasizing nursing scope, patient safety, and escalation rather than psychiatric diagnosis.

A three-tier risk stratification structure was developed to translate assessment results into immediate nursing actions. High or Imminent Risk was defined by the presence of intent with plan, access to means, inability to maintain safety, or severe acute destabilization. The corresponding pathway required immediate safety measures, continuous observation as per institutional capacity, removal or mitigation of access to means within the environment, and urgent escalation to physician/psychiatry/on-call emergency response according to local governance. Moderate Risk was defined by suicidal ideation with partial planning, fluctuating intent, or significant distress with limited protective anchoring but without immediate means access or imminent intent. The corresponding pathway emphasized increased monitoring, same-day escalation for formal mental health evaluation, rapid development of a safety plan, and structured involvement of available supports. Lower Risk was defined by passive death wishes or distress with denial of intent/plan, stable engagement, and identifiable protective factors. The corresponding pathway emphasized psychoeducation, brief safety planning, referral for follow-up support, and clear documentation and return precautions.

The stratification logic was embedded into a decision tree so that nurses could proceed from assessment findings to the appropriate pathway without interpretive ambiguity. Each pathway contained “minimum required actions” to ensure standardization, as well as “context-adaptive options” to accommodate resource variability across settings.

A structured safety planning template was produced as a protocol output to support consistent nursing practice. The template included components for identifying personal warning signs, internal coping

strategies, social distraction/support options, contact points for help, environmental safety steps, and crisis escalation instructions. The safety plan was designed to be brief, written in patient-friendly language, and suitable for documentation in clinical notes or discharge materials. The protocol specified when safety planning should occur (moderate and lower risk pathways) and identified circumstances in which safety planning alone is insufficient (high/imminent risk).

A set of communication micro-skills was generated and embedded within the Therapeutic Response module. These included structured phrasing for direct inquiry, validation statements to reduce shame and defensiveness, reflective summarization to clarify meaning, and grounding strategies for acute distress. The protocol explicitly discouraged minimizing statements, moralizing language, or overly reassurance-driven responses that may shut down disclosure. Communication guidance was aligned with a nonjudgmental, person-centered nursing stance and was presented as actionable verbal scripts adaptable to diverse patient groups.

The protocol resulted in explicit environmental safety guidance applicable to non-psychiatric settings. This included steps for reducing immediate hazards within the patient environment, identifying high-risk locations, and clarifying observation requirements within operational capacity. The workflow component clarified role boundaries, emphasizing that nurses initiate safety actions and escalation procedures but do not bear sole responsibility for risk containment. The protocol also specified “handover safety points” to ensure continuity during shift change, unit transfer, or discharge planning.

A minimum documentation dataset was produced as part of the protocol to reduce variability and support medicolegal clarity. Documentation elements included activation trigger(s), assessment summary (ideation, intent, plan, means), risk stratification category, actions taken (safety steps, escalation, referrals), patient engagement and response, safety plan completion when applicable, and follow-up arrangements. Standard wording examples were included to support consistent charting across units.

The development process produced implementation materials designed to facilitate uptake in routine care. These included a one-page protocol summary for rapid reference, a decision-tree poster format for clinical areas, and a short training outline emphasizing recognition, direct inquiry, escalation logic, and documentation. The training outputs were designed to be deliverable in brief sessions for staff orientation or continuing education.

Internal feasibility checks resulted in refinements to ensure the protocol can be applied in time-limited, high-throughput settings such as emergency departments and primary care. Refinements included simplifying branching points, reducing redundant assessment steps, and ensuring that each pathway contains clear “next actions” that do not rely on specialized services being immediately available. The final protocol was therefore constructed to remain functional across variability in staffing, access to mental health specialists, and institutional resources, while maintaining patient safety as the central priority.

4. Discussion

The present study addresses a critical gap in nursing practice by proposing a structured, evidence-based nursing protocol for suicide risk identification and early intervention in non-psychiatric healthcare settings. The results demonstrate that it is both feasible and methodologically sound to

translate existing suicide prevention evidence into a nursing-specific, operational protocol that aligns with the realities of routine healthcare environments. This contribution is particularly relevant given the persistent under-detection of suicide risk in general healthcare settings, despite frequent patient contact with nursing professionals prior to suicide-related events (Luoma et al., 2002; Stene-Larsen & Reneflot, 2017).

A central strength of the developed protocol lies in its focus on early recognition and proactive nursing engagement. Research consistently indicates that individuals at risk for suicide often present with indirect signals, such as emotional distress, somatic complaints, or psychosocial stressors, rather than explicit suicidal ideation (Turecki et al., 2019). By operationalizing observable triggers and contextual risk indicators, the protocol supports nurses in identifying risk along a continuum, rather than relying solely on overt disclosures. This approach aligns with contemporary suicide prevention models that emphasize dynamic risk processes and early intervention rather than crisis-only responses (Zalsman et al., 2016).

The protocol's emphasis on structured nursing assessment and therapeutic communication addresses well-documented barriers in nursing practice. Studies have shown that nurses frequently report discomfort and uncertainty when asking direct questions about suicide, often due to limited training and fear of causing harm (Bohanna & Wang, 2012; Saunders et al., 2014). The inclusion of clear assessment prompts and communication micro-skills within the protocol may reduce this uncertainty by normalizing direct inquiry as a routine, evidence-informed nursing action. Importantly, existing evidence suggests that asking about suicidal thoughts does not increase risk and may facilitate disclosure and engagement (Dazzi et al., 2014).

Another key contribution of the protocol is its explicit integration of escalation pathways and interprofessional collaboration. Fragmentation of care and unclear role boundaries have been identified as significant obstacles to effective suicide prevention in general healthcare settings (O'Connor & Portzky, 2018). By embedding clear criteria for escalation and referral, the protocol reinforces nursing accountability while simultaneously clarifying that suicide risk management is a shared responsibility within healthcare systems. This structured approach supports safer practice environments and reduces reliance on individual judgment alone.

From an implementation perspective, the protocol's design reflects principles of evidence-based practice and implementation science. Evidence-based practice emphasizes not only the use of research evidence but also the adaptation of interventions to contextual constraints and professional scope (Melnyk & Fineout-Overholt, 2019). The protocol was intentionally constructed to function in non-specialist settings with variable access to mental health resources, thereby increasing its potential applicability across diverse healthcare contexts. This adaptability is critical, as rigid or overly specialized protocols often fail to translate effectively into routine nursing practice.

The simulation-driven methodological approach used in this study represents an additional strength. Simulation has been increasingly recognized as a valuable tool for developing, testing, and refining clinical protocols without exposing patients or professionals to risk (Aebersold, 2018). Through repeated simulation cycles, the protocol was internally validated for coherence, feasibility, and logical consistency. While simulation does not replace empirical testing, it provides a robust preliminary foundation that enhances methodological rigor prior to real-world implementation.

Despite these strengths, several limitations should be acknowledged. The protocol has not yet undergone empirical evaluation in clinical settings, and its impact on nursing confidence, practice consistency, or patient outcomes remains to be determined. Additionally, while the protocol was designed to be broadly applicable, local organizational policies, cultural factors, and legal frameworks may necessitate contextual adaptation prior to implementation. Future research should therefore focus on pilot testing, implementation studies, and outcome evaluation across different healthcare environments.

In conclusion, this study contributes to the advancement of suicide prevention in nursing by demonstrating a systematic, evidence-based approach to protocol development tailored to non-psychiatric settings. By translating research evidence into actionable nursing guidance, the proposed protocol has the potential to strengthen early identification, enhance therapeutic engagement, and promote safer, more consistent nursing responses to suicide risk. Continued research is needed to evaluate its effectiveness in practice and to support its integration into education, policy, and routine care.

5. Conclusions

Suicide prevention is a shared responsibility across healthcare disciplines, yet nurses play a uniquely influential role due to their continuous patient engagement and holistic perspective. The construction of an evidence-based nursing protocol for suicide risk identification and early intervention provides a structured, actionable framework to support nurses in fulfilling this role. By integrating empirical evidence with nursing practice realities, such protocols have the potential to strengthen preventive care, enhance patient safety, and ultimately contribute to reductions in suicide-related harm.

References

1. Aebersold, M. (2018). Simulation-based learning: No longer a novelty in undergraduate education. *Online Journal of Issues in Nursing*, 23(2), 1–11. <https://doi.org/10.3912/OJIN.Vol23No02PPT39>
2. Bohanna, I., & Wang, X. (2012). Suicide and self-harm in the emergency department: A systematic review of epidemiology, risk factors, and interventions. *Emergency Medicine Journal*, 29(8), 642–650. <https://doi.org/10.1136/EMJ.2010.098061>
3. Bolster, C., Holliday, C., Oneal, G., & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *Online Journal of Issues in Nursing*, 20(1), 2. <https://doi.org/10.3912/OJIN.Vol20No01Man02>
4. Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine*, 44(16), 3361–3363. <https://doi.org/10.1017/S0033291714001299>
5. Hawton, K., & Williams, K. (2021). The Papageno effect and suicide prevention: A systematic review. *The Lancet Psychiatry*, 8(8), 706–717. [https://doi.org/10.1016/S2215-0366\(21\)00100-2](https://doi.org/10.1016/S2215-0366(21)00100-2)

6. Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with primary care prior to suicide: A review of 40 years of studies. *American Journal of Psychiatry*, 159(6), 909–916. <https://doi.org/10.1176/appi.ajp.159.6.909>
7. Melnyk, B. M., & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing & healthcare: A guide to best practice* (4th ed.). Wolters Kluwer.
8. O'Connor, R. C., & Portzky, G. (2018). The relationship between entrapment and suicidal behavior through the lens of the integrated motivational–volitional model of suicidal behavior. *Current Opinion in Psychology*, 22, 12–17. <https://doi.org/10.1016/j.copsyc.2017.07.021>
9. Saunders, K. E. A., Hawton, K., Fortune, S., & Farrell, S. (2014). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders*, 169, 212–224. <https://doi.org/10.1016/j.jad.2014.07.024>
10. Stene-Larsen, K., & Reneflot, A. (2017). Contact with primary healthcare prior to suicide: A systematic review. *Scandinavian Journal of Public Health*, 45(2), 135–147. <https://doi.org/10.1177/1403494816681630>
11. Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M. A., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. *Nature Reviews Disease Primers*, 5(1), 74. <https://doi.org/10.1038/s41572-019-0121-0>
12. World Health Organization. (2023). *Suicide worldwide in the 21st century: Global age-standardized suicide rates*. WHO. <https://www.who.int>
13. Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., ... Baldessarini, R. J. (2016). Suicide prevention strategies revisited: Systematic review. *The Lancet Psychiatry*, 3(7), 646–659. [https://doi.org/10.1016/S2215-0366\(16\)30030-X](https://doi.org/10.1016/S2215-0366(16)30030-X)