Chapter 16
Suicide Assessment

Role Play

The following prerequisite interviewing skills need to be mastered before role-playing suicidal assessments: maintain a slow pace, elicit feelings, ***empathic summary, feeling response, self-awareness***, clarify vague answers, ***open-ended inquiry, validity tools*** for increasing accuracy, and ***transitional statements***.

Role Play #1: A 60 yr. old woman with worsening depression is on an antidepressant. She has severe arthritis, and quit work one year ago. She lives on her own.

Objectives

1. Set the platform to inquire about suicidal thinking and behavior.
2. Use a behavioral incident to carefully carve out current suicidal thinking and behavior.

Trainee	Mrs. Jones, you say your depression is worse and the medicine doesn't seem to help. Tell me about it.
Patient	I can't get myself going in the morning. My sleep is bad.
Trainee	It sounds tough. Say more about it.
Patient	I get four to five hours of sleep a night. I feel lousy when I wake up and find it hard to get myself activated.
Trainee	Hard to get activated?
Patient	Yes. I have always been someone who was active. I worked for 30 years, and hardly missed a day. I feel lost.

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Trainee How do you mean "lost"?
Patient I don't know. I used to have a purpose with my work. Now, I feel disorganized. I wished I had a focus.
Trainee It sounds difficult
Patient It is.
Trainee So, you feel lost and have no focus. When you are feeling at your worst, do you have times when you just wish your life was over?
Patient I do wish that at times.
Trainee Have you had thoughts of killing yourself?
Patient Sometimes
Trainee Do the thoughts come and go or there all the time?
Patient I have them every day.
Trainee Have you made a plan to kill yourself?
Patient No.
Trainee Ok, I think we are finished.

Feedback

Faculty Affirmations?
Trainee #2 You clarified whether she was having suicidal thinking, not just passive thoughts. You had a good pace and appeared calm.
Faculty Yes, in addition you had a nice empathic statement when she mentioned her sleep problem. You set the platform nicely by asking what she was experiencing and not rushing through it. And you summarized well. Very nice. I have one option. I would explore her current suicidal thinking more fully. These four questions, taken directly from Managing Suicide Risk in Primary Care, will help you more fully carve this region. (1) Have you thought about how you might kill yourself? (2) When you think about suicide, do the thoughts come and go, or are they so intense you can't think about anything else? (3) Have you practiced in any way, or have you done anything to prepare for your death? (4) Do you have access to (method)? (See Table 16.1.) I wrote them down on a card. Let's run through it one more time. You can refer to this card during the interview, if you want.
Trainee Okay. I'm ready to go again.

Table 16.1 Sequencing risk assessment questions for BHCs

1. *Suicide screening*
   - Many times when people feel [describe symptoms or complaints] they also think about death or have thoughts about suicide. Do you ever wish you were dead or think about killing yourself?
   - Do things ever get so bad you think about ending your life or suicide?
2. *Differentiate suicidal ideation from nonsuicidal morbid ideation*
   - Tell me a little bit about what, specifically, you have been thinking.
   - What is it exactly that goes through your mind?
   - When you think about dying, is it because you have caused it to happen?
3. *Assess for past suicidal behaviors*
   - Have you ever had thoughts like this before?
   - Have you ever intentionally injured yourself in any way before?
   - Have you ever tried to kill yourself before?
   - So you've never cut yourself, burned yourself, held a gun to your head, taken more pills than you should, or tried to kill yourself in any other way?
4. *If positive history of suicidal behaviors, assess multiple attempt status*
   - How many times have you tried to kill yourself?
   - Let's talk about the first time…
     (a) When did this occur?
     (b) What did you do?
     (c) Where were you when you did this?
     (d) Did you hope you would die, or did you hope something else would happen?
     (e) Afterward, were you glad to be alive or disappointed you weren't dead?
   - Let's talk a little bit about the worst time you attempted suicide; the time you were most suicidal and tried to kill yourself…

[Repeat (a) through (e) above]

5. *Assess current suicidal episode*
   - Let's talk about what's going on right now. You said you've been thinking about [content].
   - Have you thought about how you might kill yourself?
   - When you think about suicide, do the thoughts come and go, or are they so intense you can't think about anything else?
   - Have you practiced [method] in any way, or have you done anything to prepare for your death?
   - Do you have access to [method]?
6. *Screen for protective factors*
   - With all that's been going on, what is keeping you alive right now?
   - What prevents you from killing yourself?

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Replay

Trainee	Tell me how you think your medicine for depression is working.
Patient	It does not seem to be working. I can't get myself going in the morning.
Trainee	Tell me more about it.
Patient	I have always been an active person. I worked for 30 years, and hardly missed a day. I feel lost.
Trainee	How do you mean "lost"?
Patient	I don't know. I used to have a purpose with my work. Now, I feel disorganized. I wished I had a focus.
Trainee	It sounds difficult
Patient	It is.
Trainee	When you are feeling real bad do you have thoughts of ending your life, of suicide?
Patient	Sometimes.
Trainee	Would it be okay if I ask a few questions about those thoughts?
Patient	Go ahead.
Trainee	Have you thought about how you might kill yourself?
Patient	I have thought of taking all my pills. I haven't considered anything else.
Trainee	When you think about suicide, do the thoughts come and go, or are they so intense you can't think about anything else?
Patient	They come and go. I rarely think about it.
Trainee	Have you practiced in any way, or have you done anything to prepare for your death? For example, have you picked up the pill bottle with thoughts of taking an overdose?
Patient	No, I would never do it. I don't want to leave my grandchildren.
Trainee	Do you have easy access to pills.
Patient	They are right there in my medicine cabinet.

Feedback

Faculty	Good job. You got a clearer picture of her current suicidal thinking.

Role Play #2: Melissa is a 14-year-old girl in your office after her mother discovered her diary detailing cutting behavior. Melissa is upset. Both her parents are present. She has no history of suicidal ideation or behavior in the past. She has been depressed for a year and has been cutting herself.

Objectives

1. Ask adolescent about suicidal thoughts.
2. Check out family perspective.

Trainee	I am Dr. Black.
Parents	Hi. We are Bob and Stacy Shaw. This is Melissa.
Trainee	Before we get started talking about the reason for today's visit, I am going to ask you to tell me a little about yourselves. I like to get to know people as people before discussing their medical concerns. Is that okay with you?
Everyone	Yes.
Trainee	Melissa, let's start with you. Tell me about yourself.
Patient	What do you mean?
Trainee	Who are the important people in your life? What do you like to do? How is school, family? Whatever you think it would be important for me to know.
Patient	I'm a sophomore in school. I am in the band. Most of my friends are members of the band. I play the clarinet.
Trainee	How long have you played the clarinet?
Patient	Two years.
Trainee	I imagine you like it?
Patient	I do like it a lot.
Trainee	So, you are a sophomore in high school. You are in the band along with your friends. Tell me more.
Patient	I have 2 brothers. My older brother goes to my high school. We get along okay.
Trainee	Good. Let me switch to you, Mrs. Shaw. Tell me about yourself.
Mother	I am a paralegal. I work in a lawyer's office part time. We have three children. Melissa is the middle child. I am very concerned about her right now.
Trainee	We will get to that in 1 minute. Would you say more about yourself?
Mother	I think her father and I have both had stresses between work and his family. Bob's father died a year ago. He was very close to Melissa. In addition, I have had some medical problems and had to go through some testing, recently.

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Trainee	Say more about yourself.
Mother	I am close to my children. They are my number one priority. However, I have not been as available to the children since I became ill.
Trainee	So, you have been facing a lot of change and stress as a family.
Father	Yes, my mother now lives by herself. I have been busy helping her and have not been around as much as I used to be.
Trainee	Not around as much as you used to be?
Father	My mother can be demanding. I want to help as much as I can, but I have only so much time.
Trainee	It does sound like it has been a lot to deal with.
Mother	It has been a challenge. Our biggest concern is Melissa.
Trainee	Tell me more about your concerns. I do know a little bit from your call to me yesterday, Mrs. Shaw.
Mother	As I was telling you yesterday, I discovered that Melissa and a friend have been cutting on themselves. I am real worried about her.
Trainee	Melissa, is there anything else that you want to make sure we discuss during today's visit
Patient	No.
Trainee	I am going to shift gears now… I would like to talk to you all about today's visit. Melissa, I plan to talk with you alone for part of the visit. Afterwards, I would like to talk with you and your parents together. I will keep everything private. I do this so you can feel free to talk with me. There is one exception. If you tell me anything that makes me concerned about your safety, or the safety of someone else, I would talk with your parents about it. Is that plan okay with you?
Melissa	Yes.

Parents also agree and then leave the room.

Trainee	Tell me your perspective on the situation. Do you know your mother called and gave me a brief overview yesterday?
Patient	Yes. She got all upset when she found out I have been cutting.
Trainee	Before you tell me about the cutting, I would first like to ask you some questions that will help me better understand the bigger picture.
Patient	Okay.

(continued)

Trainee How has your overall mood been in the last two weeks?
Patient I've been down.
Trainee What do you mean?
Patient I have not felt like myself. I don't feel like doing anything. I have to force myself to do my homework, and it takes me forever.
Trainee Sounds difficult. Say more about that.
Patient I don't know what is going on. Sometimes I feel really bad.
Trainee Really bad?
Patient It is hard to explain.
Trainee I imagine it is confusing to feel bad and not know why.
Patient It has been hard.
Trainee When people feel really bad they often have thoughts of killing themselves. Is that true for you?
Patient Not really.
Trainee What thoughts have you had?
Patient I've wondered what it would be like to die.
Trainee When you think of dying is it because you caused it to happen.
Patient No, I never thought that.

The trainee goes on to obtain details about Melissa's depression, the cutting, and her view of family relationships. The parents are then invited back into the office.

Trainee Mr. and Mrs. Shaw, I would like to hear your perspective.
Mother I am very concerned. I found her writing about cutting herself. She and her best friend have been doing this for quite a while. We took away all sharp objects. We are watching her constantly. I don't know when I will be able to trust her again.
Father I am very concerned. She has been spending too much time in her room. I know teenagers do that, but I think she needs to be more involved with the family. We have always done things together. We are a close family.
Patient Okay, I'll spend more time with you.
Mother There is the note in her diary. I think it was a suicidal note.
Patient Mom, it is not a suicidal note.
Mother What is it?
Patient I just have not been myself. I don't know what is wrong.
Trainee Let me jump in here. Melissa, you have a clinical depression. The cutting has been your attempt to cope with very painful feelings. You were very close to your grandpa and he died last year. Your mom has

(continued)

	been dealing with a serious medical problem and you have been worried about her. Adding to your losses, you have felt ostracized by some of the kids at school. This has all contributed to your depression. The depression is treatable.
Mother	I knew she was not herself. The cutting has really upset me. We are going to have to watch her constantly.
Trainee	Let's talk about safety.

Feedback

Faculty	Okay, great job, let's stop. (*to trainee*) What did you like about your interview?
Trainee	I thought I had a good connection with the patient and family. I tried to be thorough. I explained what I was doing all along.
Faculty	Other affirmations?
Mother	I thought you listened carefully to my concerns. You took everybody's view into account.
Trainee #2	You used normalization to ask about suicide. You said that people often have thoughts of suicide when they feel real bad.
Trainee #3	You did a great job staying calm, even though the parents were upset about the cutting.
Faculty	You did a careful assessment. You addressed privacy issues. You got a personal story. I think that was a good way to begin since you didn't know the family. You set the platform before asking about suicide. You had a good structure for the interview. I like the way you brought the parents in to get their perspective. It is important to get collateral data to make sure you are not missing anything. Also, you saw they want to be supportive. That is crucial data.
Trainee	Thanks.
Faculty	Does anybody have options?
Group	(*no response*)
Faculty	I have one. I noticed that your pace became a little fast at times. Did you notice that?
Trainee	Yes, I think you are right.
Faculty	Good awareness. It is very easy to hurry when there is so much crucial data to obtain. It is important to go slowly when doing a suicide assessment, so the patient feels safe to talk. If you stay aware, you can take a breath, slow yourself down and be fully present.
Trainee	Thanks. I will keep that in mind.

Role Play #3: Melissa, age 14, and her family. Continue where Role Play #2 concluded.

Objectives

1. Establish a clear contract to perform means restriction counseling
2. Use an empathic summary if family has difficulty with this issue

Trainee I would like to talk to you about one more topic. Melissa has depression and we know that is a risk factor for suicide. We all want to help her feel better and stop suffering. In order to do that, it is important that she stay safe and alive. Even though Melissa has stated she is not suicidal, depression can feel unbearable at times and lead to suicidal thoughts. Therefore, I would like to talk with you about making the environment safe. You know, firearms, knifes, pills,… Is that okay with you?

Mother Sure

Father Of course I want my daughter to be safe. But, I have always had a gun. I am a hunter and gun collector.

Trainee You have always owned a gun. I imagine the thought of removing firearms sounds like a huge step. Of course, you want to keep your daughter safe.

Father Yes.

Trainee Well, let's look at our options. We are not talking about a permanent situation.

Father Okay. How long are we talking about?

Trainee I would recommend removing firearms out of the house for minimum of six months after the depression has resolved.

Father I will take care of that today.

Trainee I would like to write our safety plan down so we are all on the same page.

Feedback

Faculty Let's stop. Wonderful job. You obtained a clear contract. You did not debate with the father. Instead you used an empathic summary. This helped you maintain a partnership with him based on the common goal of alleviating Melissa's suffering. Finally, you were open to collaborating with the father and informed him this was a temporary approach. (See section on Means Restriction Counseling.)

Obstacles to Teaching Suicide Assessment

1. Interviewer has a hidden belief (e.g., suicide is a sign of weakness) that interferes with a nonjudgmental attitude.
2. Fear of dealing with intense dysphoria.
3. There is limited time for role plays. Learning how to perform a good suicidal assessment takes repetition and time.
4. Lack of knowledge.

Strategies

1. Use group process to discuss clinician's attitudes and thinking when assessing suicide.
2. Empathize with the learner. Explore what underlies the clinician's fear, and normalize reactions. Faculty member can demonstrate techniques for dealing with intense affect.
3. Set aside enough time. It is an essential skill for all clinicians!
4. Teach a sequential and hierarchical method that is both efficient and readily learnable.

Suicide Assessment in Primary Care

Forty-five percent of people who die by suicide contact a primary care clinician in the month before their deaths [1]. An opportunity exists for primary care clinicians to identify high-risk individuals and intervene to prevent suicides [2, 3]. It is important for a primary care clinician to have a systematic, organized approach. Most mistakes in suicide assessment are made as a result of errors of omission, distortion, and false assumptions, rather than as a result of bad decisions with a complete database [4]. The patient's risk factors and the patient's unique suicidal thinking and plans comprise the essential elements of a complete database [5]. The focus in this chapter is on practical interviewing strategies that a primary care clinician or a behavioral health consultant working in primary care can utilize to uncover a patient's unique suicidal thinking and plans. The first strategy is staying self-aware.

Interfering Cognitions

Establishing an atmosphere that supports emotional contact and safety to talk can be extraordinarily difficult with a patient who feels shame, harboring a suicidal secret. Many patients have strong negative beliefs about their own suicidal thinking. Some

believe suicidal thoughts represent a character weakness or signify that they are crazy; others see suicidality as a sinful or taboo subject; and many believe nobody can help them, so they see no purpose for sharing their secret [4].

Physicians also hold any number of beliefs and attitudes that can create a strong emotional reaction and interfere with a good suicidal assessment. Physicians, like patients, may consider suicide as a sign of weaknesses, craziness, or sin; they may consider suicide a taboo subject, or the situation to be hopeless. A physician holding onto any of those beliefs will convey judgment or disapproval to the patient. A patient attuned to the nonverbal signals of the clinician, such as a disapproving face, fast pace, or change in the tone of voice, may assume disapproval and then remain alone with his or her secret [4].

A second group of beliefs and attitudes, just as incapacitating as the first group, almost always remain covert. A physician who uncovers suicidal thinking or behavior will need to spend extra time and energy in order to properly evaluate and triage that patient [4]. In addition, appropriate mental health referrals can be difficult to access. A busy clinician might hope that a patient is not suicidal, so he or she would not be required to spend the extra time evaluating the patient. Although an understandable desire, it is damaging to convey this wish to a patient who is already ambivalent about sharing a suicidal secret. Shea lists another clinician attitude that interferes with a competent suicide assessment: clinicians want to avoid anxiety. No clinician wants to worry about a patient when he or she finishes the workday and goes home to family, worry that can be expected by the clinician who has triaged a suicidal patient earlier that day [4]. Instead of fleeing from this anxiety, the clinician must face it directly by considering and answering two questions [4]:

- What am I feeling right now?
- Is there any part of me that doesn't want to hear the truth right now?

A clinician establishes an atmosphere of safety by first doing a careful self-examination and resolving any internal biases. The clinician must then help diminish the shame that many patients experience with suicidal thinking. This shame results from deeply held beliefs about suicidality, noted above. A direct confrontation of these beliefs usually leads to a defensive reaction and poor engagement. The clinician needs a softer approach. Shea suggests two specific strategies for addressing this shame and secrecy: setting the platform and use of validity techniques [4].

Setting the Platform

The more we understand our patients' suffering, the more engaged we can be with our patients. By talking about their suffering, patients will be more likely to share their suicidal state as they seek relief from a painful depression or a state of "crises, anger, anxiety, and hopelessness" [4]. The interviewer enters into the patient's

experience of pain and uses that as a gateway to ask about suicidality. Asking about suicidality in that context feels natural and not like the question has been "popped" [4]. Two conclusions result from this understanding of suicidal assessment:

1. Establishing a strong engagement in order to obtain a full database takes on added importance when performing a suicide assessment. A hurried pace is likely to disengage the patient; it is important for a clinician to monitor his or her pace.
2. Since the patient's nonverbal signs (e.g., fidgetiness, avoidance of eye contact) communicate information of which he or she may be unaware, it is particularly important for the clinician to stay fully present and attuned to the patient.

A primary care clinician must decide who to assess for suicidal thoughts and behaviors. Since suicide is the leading cause of death in 15–19-year-olds, the American Academy of Child and Adolescent Psychiatry recommends screening this group for current and past suicidal ideation/behavior, substance abuse, and depression [6]. The U.S. Preventive Services Task Force does not encourage or discourage screening in adults because of insufficient evidence to make a recommendation [3]. The adult clinician might respond to this USPSTF position in one of several ways:

1. Use a questionnaire, such as the PHQ-9 to screen all patients for depression and suicide. The sensitivity and specificity of this instrument are adequate [7].
2. Ask about suicidality in select patients, such as those with depression, other mental health disorders, or physical conditions complicated by disability. The advantage of this approach is that it can be done without placing a burden on the practice to assess, track, and treat a large number of identified patients. A critical disadvantage is that it misses the vast majority of patients and the opportunity to treat those patients—potentially decreasing morbidity and mortality [8].

Once the patient is fully engaged with the interviewer and in touch with the psychic pain of the suicidal state, the clinician inquires about suicidal ideation [4]. If a patient appears anxious, the clinician might start off with a mildly ambiguous question, as a gentle way to bring up the topic of suicide [4]. *Are there ever times when you wish your life were over*?

The clinician would follow this question with a specific inquiry into thoughts of killing oneself.

Normalization

In the following example with an adolescent, depression is used as the gateway to a suicidal inquiry. N**ormalization** is used to increase the likelihood of accurate reporting by the patient.

Patient	My friends get on my nerves. Most of the time, I just hang out in my room.
Clinician	What's that like?
Patient	I feel really bad. I'm all alone.
Clinician	Tell me about being alone.
Patient	It feels like no one cares about me (*looks sad*). I don't have anyone to talk to besides my dog.
Clinician	(slows pace, softens voice) You feel alone. Tell me more about that.
Patient	I don't know. I cry sometimes. I feel so all alone. Even my best friend Shelly has abandoned me. She doesn't call me anymore.
Clinician	It sounds difficult. Lots of folks who feel alone and down in the dumps have thoughts of wishing their life was over. Is that true for you? (*normalization*)
Patient	Sometimes.
Clinician	Have you thought of ending it all, of killing yourself?
Comment	*The clinician asks directly about killing oneself or being suicidal—not just hurting oneself. This area is too important to have miscommunication about what the patient means [9].*

Database

A positive response to a suicidal inquiry leads to a full suicidal assessment. Wishing one were dead without specific suicidal thinking (*It would be okay if I didn't wake up in the morning*) is not considered a positive screen. Since these patients have a lower suicidal risk, a different clinical response is required, such as treating the underlying condition and monitoring their morbid ideation regarding death [10].

The database in a suicide assessment may be large. An organized, systematic interview is required to gather all the data needed to make a sound diagnosis and treatment plan. "Winging it" is a common human response when facing a potentially large database [11]. "Winging it" results in errors of omission. Splitting the data into a sequence of smaller regions allows the clinician to more easily recall the information needed for each region [11].

Several methods for sequencing and organizing the patient's unique suicidal experience have widespread clinical acceptance [10, 11]. The CASE (Chronological Assessment of Suicidal Events) method sequences the data into four separate time regions; each region is associated with specific techniques to enhance accuracy [11]. The CASE method has been successfully taught to mental health professionals, as well as primary care clinicians via macrotraining [11]. Macrotraining utilizes repetitive role plays to achieve overlearning the material [11].

Bryan and Rudd describe a second empirically based sequencing method. The data collected are prioritized according to its predictive value for suicidal behavior. This is time efficient, and important, given the time limits inherent in primary care [10]. Evidence has supported these questions, among hundreds that could be asked about risk factors, as having the greatest risk of suicide. Primary care clinicians and behavioral health consultants working in primary care do not have time to ask hundreds of questions. However, they do have time to build the history together, weaving in open-ended questions, such as: *Tell me about the first time you tried to kill yourself* [10]. Questions are sequenced so that patient anxiety is decreased and, consequently, accuracy is increased. The clinician begins with less emotionally intense questions, and then moves to repetitive, highly specific questions as the patient becomes comfortable discussing suicide [4].

Once a clinician has determined that the patient needs a suicide assessment, he or she must evaluate risk factors. Risk factors include predisposition to suicidal behavior (e.g., history of psychiatric diagnosis, history of abuse), identifiable precipitant or stressors, symptomatic presentation (e.g., current mood symptoms), presence of hopelessness, previous suicidal behavior, impulsivity, self-control (e.g., substance abuse), access to lethal means, protective factors, and **the nature of the suicidal thinking** [12]. As previously noted, this chapter focuses on asking about the actual suicidal thoughts and behaviors of the patient.

A synopsis of Bryan and Rudd's sequencing structure for assessing suicidal thoughts and behaviors from *Managing Suicidal Risk in Primary Care* follows. It was the structure used for the role-play scenarios at the beginning of the chapter.

Assess for Past Suicidal Behaviors

Past suicidal behavior is "the single most significant and robust predictor of future suicide attempts and death by suicide across the entire life span" [10]. The likelihood of accuracy in this area is enhanced by gradually increasing the intensity of questions:

Have you ever had thoughts of suicide like this before?
Have you ever tried to kill yourself before?

If the second question is answered negatively, a third question follows:

So, you've never cut yourself, burned yourself, held a gun to your head, taken more pills than you should, or tried to kill yourself in any other way? [10]

Denial of the specific technique potentially increases accuracy. For example, a patient, who has held a gun to his head, might say he has not tried to kill himself, since he didn't pull the trigger, and then answer the denial of the specific question honestly.

Screen for Multiple Attempts and Assess Attempt History

A patient with a history of past suicidal behavior is asked about the first episode and the most serious episode (Table 16.1). The worst-point suicide attempt is more closely associated with future suicidal behavior than the current crises in chronic attempters [13]. This past information reveals the patient's behavioral pattern and intent over time, and contributes to a good management plan for the current episode [10].

Assess the Current Suicidal Episode

Since most patients will not report a history of prior suicidal behavior, the clinician can move directly to current suicidal thinking. The clinician might move to this area with a transition statement: *Earlier you were telling me about your thoughts of ending your life. Tell me more*.

The clinician wants to create a "verbal videotape" of the patient's suicidal thinking and behavior [11]. He or she tracks carefully with the patient, filling in any missing information with the following focused questions:

> *Have you thought about how you might kill yourself?*
> *When you think about suicide, do your thoughts come and go, or are they so intense you can't think about anything else?*
> *Have you practiced [method] in any way or have you done anything to prepare for your death?*
> *Do you have access to [method]?*
>
> [10, p. 78]

If a patient is hesitant to talk, the clinician can simply ask the patient what he or she thinks would happen if he or she were to disclose fully. In that way, any block to openness is made overt and can be discussed [10]. If the patient does not answer questions directly, or even if the patient does, collateral information from family, friends, professionals, and others can be invaluable. It is crucial in adolescent evaluations [14].

Screen for Protective Factors

The patient's reasons for living are supported with a back-and-forth conversation, not simply listed. Protective factors do not eliminate risk factors, but are part of the total picture and often provide clues for developing interventions and management strategies [10].

Means Restricting Counseling

Since most patients in primary care are not directly admitted to the hospital, a crises response plan (CRP) is needed. This is a written plan developed collaboratively with the patient as an aid to follow during a period of crisis [10]. Part of working with patients, families, and other support systems during a crisis entails limiting access to firearms and other means of suicide. Means restriction counseling is supported by expert opinion as an important risk management strategy [15]. Bryan et al. recently published a protocol they have used successfully for means restriction counseling with suicidal patients [15]. The protocol outlines an approach developed to avoid an adversarial relationship—a potential consequence of recommending removal of firearms or other means of suicide, such as pills, from the environment. The interviewing steps include:

1. Join with the patient. Restricting means is very difficult for some patients. Take an empathic stance and do not argue. Alleviating suffering is a common goal around which the patient and clinician can join without arguing [15].
2. Present a menu of options. For example, if a patient is unwilling to remove a gun from the home, the following options can be suggested: "Dismantle firearm and give critical piece to significant other; store firearm in tamper-proof safe secured by a significant other; completely remove ammunition" [15]. Hiding the firearm would not be offered as an option since that is not safe. All firearms are identified and handled similarly.
3. Use a means receipt to ensure that the plan has been implemented. The receipt is a written agreement between the patient and clinician. It is signed by a significant other and returned. It includes the specifics of what is being restricted, how it is being restricted, and the specific conditions under which the means will be returned. The temporary time frame can instill hope for the patient and reduce resistance [15].

Note

The primary care clinician must also be knowledgeable about treatment options in order to discuss them with the patient. This holds whether the patient has been referred to specialty care, or the clinician provides primary treatment of an underlying mental condition, such as depression. McDaniel et al. recommend that "All patients with active suicidal thoughts should be referred to a mental health professional, and those with plans need urgent evaluation. Those with the means and intent to commit suicide usually need immediate hospitalization." [16, p. 352].

One common area of misinformation regarding treatment relates to the Food and Drug Administration's 2004 black box warning on selective serotonin reuptake inhibitor (SSRI) antidepressant use in patients 24 years and younger. Misunderstanding of the warning by both clinicians and patients may have had the

unintended consequences of reducing prescriptions of SSRIs, without stimulating a compensatory increase in other forms of treatment of depression (e.g., Cognitive Behavioral Therapy), for children, adolescents, and young adults [17, 18]. This change in clinical practice has been temporally associated with an increase in completed suicides in children and adolescents [18]. (For a full discussion, see Rudd et al. [17] and Bryan and Rudd [10].)

Key Points

1. Learning to screen and assess suicidal ideation/behavior well takes practice and repetition.
2. A sequential and hierarchal assessment approach provides essential information efficiently. This is important given the time constraints in primary care.
3. Sequencing the order of questioning can minimize patient anxiety and lead to more accurate self-report.
4. A large database is much easier to learn when organized into distinct, smaller regions.
5. Most suicidal assessment errors are made from omission, distortion, and false assumptions—not bad clinical decisions, made with a full and accurate database.
6. Techniques to increase accuracy are essential when asking about suicidal ideation because of the shame some patients experience.
7. Vague answers need to be clarified.
8. Repetitively inquiring into the key aspects of a patient's thinking decreases the likelihood that he or she will omit important data.
9. A past history of suicidal behavior is the most significant predictor of future suicidal attempts and death.
10. It is important for clinicians to take a collaborative approach; attempts to talk the patient out of suicidal thinking lead to resistance. Relief of suffering is a common goal.
11. Talk to third parties to assess any discrepancies.
12. Family involvement is crucial in adolescent evaluations.
13. Means restriction counseling is based on expert opinion.

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