SUICIDE PREVENTION
Screening and safety planning workshop for primary care settings

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Many thanks to Shelly Nakaishi, CPNP, for her contributions to the slide deck

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Learning Objectives
- Discuss validated screening tools for depression and suicidal risk
- Distinguish among low, medium and high levels of risk for imminent suicide
- Analyze intrinsic and environmental protective factors for suicidal youth
- Practice the steps to creating a suicide safety plan.
- Review clinic protocols at primary care or SBHC sites for suicidal children & youth, including patient safety, behavioral health & emergency services

Quick Case
SUICIDE ATTEMPT: YES or NO?

Jill was mad at her boyfriend
She researched how many Advil pills to take so that it would not kill her
She took them alone in the school bathroom and told her boyfriend
Boyfriend is seen in school health clinic and tells you the provider
You meet her that day and Jill tells you did not want to die, she wanted to scare her boyfriend

NO.

Quick Case
SUICIDE ATTEMPT: YES or NO?

After Jill failed her math test, she took a razor and made a superficial cut on her wrist in the locker room because she wanted to die
The PE teacher had Jill seen in the school based health clinic to check the cut on her wrist

Continuum of Suicidal Behavior
- Death by suicide
  - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior
- Suicide attempt
  - A non-fatal self-directed potentially injurious behavior (may or may not result in injury) with any intent to die as result of the behavior
- Suicidal ideation
  - Thoughts of suicide that can range in severity from a vague wish to be dead to active suicidal ideation with a specific plan and intent
**Term** | **Definition**
--- | ---
Suicide Attempt | A self-injurious act committed with at least some intent to die as a result of the act; there does not have to be any injury, just the potential.
Non-Suicidal Self-Injurious Behavior | Feel better or relieve internal pain.
Aborted Attempt | Takes steps to end life, but someone or something stops them.
Interrupted Attempt | Takes steps to end life, but they stop themselves.
Preparatory behaviors | Any other behavior with suicidal intent — collecting pills, buying a gun, writing a suicide note.
Suicide Ideation | Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one’s life.
Suicide Contagion | Process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides.

**BACKGROUND ON SUICIDALITY**
Definition, statistics, and current programs

**Suicide Statistics**
- Suicide is the 2nd leading cause of death among teenagers (CDC, 2015) and young adults (15-34). Firearms used in 50% of completed suicides aged 15-19 y.o.
- Boys and young men are more likely than girls and young women to die from suicide.
- Ingestion of pills most common method of attempted suicide among adolescents. Other common methods are firearms and suffocation.

**Death by Suicide**
- Evenly distributed by the SES
- Evenly distributed by educated vs. uneducated
- 50% were never in therapy
- 75% communicated thoughts about their suicide aloud to several people months before dying
- Individuals of all races, creeds, incomes and educational levels die by suicide. There is no typical suicide victim.

**Developmental Snapshot**

**Highest risk for suicidality**
- ~20% of people who die by suicide have made a prior suicide attempt
- Suicide risk appears to be especially elevated after hospitalization for a suicide attempt (esp if dx of major depression, bipolar disorder, and schizophrenia)
- Hopelessness, “no way out” feeling

(Tidemalm, Langstrom, Lichtenstein & Runeson, 2008)
**RISK FACTORS**

**PERPETUATING CONDITIONS** (Unchangeable)
- Family history of suicide, mental illness, substance abuse
- Race
- Gender
- Genetics
- Unrealistic parental expectations
- Abuse (emotional, physical, sexual)
- Major family conflict
- Exposure to suicide of family member
- Anniversary of death
- Moving often

**PREDISPOSING CONDITIONS** (of Serious Concern)
- Loss through death, abandonment, divorce
- Previous suicide attempt
- Mental illness
- Substance abuse
- Extreme Perfectionism
- Poor coping/social skills
- Impulsive
- History of self-harm
- Current acute mental illness
- Recent psychiatric hospitalization
- Severe stress/anxiety
- Isolation
- Rejection
- Relationship break-up
- Increased use of substances

**PRECIPITATING CONDITIONS** (Acute)
- Inconsistent, neglectful or abusive parenting
- Sexual orientation
- Experience of repeated loss
- Chronic severe stress
- Ongoing harassment
- Active suicide cluster in community
- Access to lethal means
- Bullying, harassment
- Loss of freedom (e.g., incarceration)

**SUICIDE WARNING SIGNS**

- Talking About Dying - Any mention of dying, disappearing, jumping, shooting oneself, or other types of self-harm
- Change in Personality - Sad, withdrawn, irritable, anxious, tired, indecisive, or apathetic
- Change in Behavior - Difficulty concentrating on school, work, or routine tasks
- Change in Sleep Patterns - Insomnia, often with early waking or oversleeping, nightmares
- Change in Eating Habits - Loss of appetite and weight, overeating
- Fear of losing control - Acting erratically, harming self or others

**CONSULTATION & CREATING A TEAM**

1. When working with a suicidal individual, do not make decisions or act alone (have a protocol in place)
2. Have a team in place to carry out the protocol:
   - Other providers to see your pts?
   - BH on site or on call?
   - Staff to work with pt/family and keep safe
3. Consultation recommended for ALL professionals
   - Increases support, reduces anxiety
   - Helps to determine risk level and appropriate interventions

**CRISIS PROTOCOLS**

1. Laws: state psychiatric emergency, confidentiality, HIPAA and FERPA
2. Screening & Assessing
3. Informing – school, parents
4. Transportation
5. Documentation
6. Training
7. Security & Safety monitoring
8. Consultations
9. Re-entry, F/U Visits

**SUCIIDE SCREENING ALGORITHM**

- If suicide attempt made – it is critical to make sure follow-up mental health care is obtained after psychiatry hospitalization (greatest time of risk)
Non–Suicidal Self Injuries (NSSI)

- A volitional act to harm one’s body without intent to die
- An attempt to cope with emotions
- A way to control physical pain and distract from emotional pain
- A communication-seeking not attention-seeking behavior
- A “disorder of coping”
- Higher risk of suicide

NSSI: Behavior and Suicide

- Youth who have NSSI are 9 times more likely to make suicide attempt
  - 10% actually complete suicide
- 50-90% engage in some suicidal behavior
- Longstanding depression with hopelessness
- Desperation, impulsivity, addictive-like nature of SI can lead to suicide attempts

(Smith, Eckenrode, & Silverman, 2007; Monshields & Gutierrez, 2004; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006)

Suicide Screening & Assessment Tools

<table>
<thead>
<tr>
<th>Suicide Screens</th>
<th>Suicide Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 Adolescent – free</td>
<td>SAHMSA Suicide Assessment Five-step Evaluation and Triage (SAFE-T)</td>
</tr>
<tr>
<td>ASQ Suicide Screening Questions (ASQ) - for emergency room – free</td>
<td>Columbia Suicide Severity Rating Scale Primary Care (C-SSSR) – free</td>
</tr>
<tr>
<td>Columbia Suicide Severity Rating Scale Primary Care (C-SSSR) – free</td>
<td>Suicide Behavior Questionnaire (for adults)</td>
</tr>
<tr>
<td>Suicide Behavior Questionnaire (for adults)</td>
<td>Suicide Ideation Questionnaire (12-18 year olds) $</td>
</tr>
<tr>
<td>Suicide Behavior Questionnaire (for adults)</td>
<td>Columbia Suicide Severity Rating Scale &amp; SAFE-T</td>
</tr>
<tr>
<td>Suicide Behavior Questionnaire (for adults)</td>
<td>Collaborative Assessment and Management of Suicidality (CAMAS)</td>
</tr>
<tr>
<td>Suicide Behavior Questionnaire (for adults)</td>
<td>Linehan L-RAMP (Dialectical Behavior Therapy)</td>
</tr>
</tbody>
</table>

PHQ-9 – Adolescent, with suicide screen

Screen

<table>
<thead>
<tr>
<th>Thoughts that you would be better off dead, or of hurting yourself in some way?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes to any = Positive Screen</td>
</tr>
<tr>
<td>Go to question #5</td>
</tr>
</tbody>
</table>

asQ

Screen

Yes to any = Positive Screen

Go to question #5

Question #5 references exactly

Yes = suicide positive screen (suicidal ideation – do not leave patient alone)
Columbia Suicide Severity Rating Scale (C-SSRS)

- Anyone can administer, no mental health training required, collateral input
- Ideation - type and intensity
- Behavior - actual, interrupted, aborted, preparatory
- Screening (severity and all behaviors into 1 question) and full version

SCREEN

Columbia Suicide Severity Rating Scale

- Suicide Intent without Specific Plans
  - Akenebroad thoughts of killing oneself, and acted on it
  - Have you had those thoughts, and had any intention of acting on them?

- Suicide Intent with Specific Plan
  - Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out
  - Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out your plan?

- Suicide Behavior Question
  - Have you ever done anything, started to do anything, or prepared to do anything to end your life?
  - Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note

- Suicide Risk History
  - Have you done this within the past 2 months?

Suicide Assessment

- Directly asking
- Screening by self-report (PHQ-9 Adolescent)
  - Tend to be oversensitive & under-specific & lack predictive value
  - If yes, should always be assessed clinically
- Interview adolescent alone
- Part of SSHADESS/HEADSS during mood/depression screen
- Use a suicide assessment tool (i.e. SAFE-T, C-SSSR, SLAP)
- Complete a physical exam – special attention to skin exam, low threshold for toxicity screens and pregnancy

Suicide Assessment & Documentation: 5 steps

1. Risk factors
2. Protective factors
3. Suicide inquiry: SLAP (suicide plan, lethality of means, availability of resources, proximity of supportive person)
4. Determine suicide risk (severe, moderate, low) & Intervention
5. Document risk assessment, rational for intervention, follow-up plan
### Suicide Risk Severity

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>No identifiable suicidal ideation. No suicide plans or intent, good self-control, mild dysphoria, few other risk factors &amp; identifiable protective factors including available social support.</td>
</tr>
<tr>
<td>Mild</td>
<td>Suicidal ideation of limited frequency, intensity, duration and specificity. No suicide plans or intent, good self-control, mild dysphoria, few other risk factors &amp; identifiable protective factors including available social support.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Frequent suicidal ideation with limited intensity and duration, some specificity in terms of plans, no intent. Severe dysphoria, impaired self-control, multiple risk factors, few if any protective factors, particularly a lack of social support.</td>
</tr>
<tr>
<td>Severe</td>
<td>Frequent intense and enduring suicidal ideation, specific plans, no subjective intent but some objective markers of intent  (i.e. method chosen &amp; accessible, some limited preparatory behavior). Severe dysphoria, impaired self-control, multiple risk factors, few if any protective factors, particularly a lack of social support.</td>
</tr>
<tr>
<td>Extreme</td>
<td>Frequent intense and enduring suicidal ideation, specific plans, clear subjective and objective intent. Severe dysphoria, impaired self-control, many risk factors, no protective factors.</td>
</tr>
</tbody>
</table>

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### TREATMENT PLAN

**Wellness:** Exercise, social activities, good sleep, healthy eating

**Identify coping skills:**

**Psycho-education about depression, SI**

**Safety planning & Means Reduction**

**Family/caregiver engagement**

**Primary care**
- Follow-up telephone call
- Follow-up clinic visits
- Psycho-pharmacology treatment
- Behavioral health support

**Referrals as indicated**
- Behavioral health/social work/therapy/Psychiatry (MD,PMHP)
- Other referrals: substance abuse, housing, food, school supports, etc.

**Mobile crisis support**

**Intensive outpatient treatment**

**Partial hospitalization**

**Psychiatric hospitalization**

**Residential treatment**

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### Brief Interventions

1. Discuss confidentiality at beginning of session
2. Create a positive connection, validate emotional pain
3. Generate hope, identify and reinforce reasons for living
4. Identify coping skills and practice (grounding, mindfulness)
5. Maintain position that suicide in an ineffective or maladaptive solution to current problem
6. Problem solve safety plan barriers

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### Safety Planning

1. Warning signs/triggers
2. Coping strategies
3. Social supports
4. Professional supports
5. Means restriction
6. Follow-up plan
7. Communication plan
8. Ask for commitment

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### Treatment Options... but therapy is a MUST

Two effective modalities for attempted suicide:

- Cognitive behavior therapy (CBT)
- Dialectical behavioral therapy (DBT) – good for youth with borderline traits and/or recurrent ideation

Also helpful:

- Family therapy – e.g. Attachment Based Family Therapy with Suicidal Adolescents (ABFT)
- Medication
Psychiatric Hospitalization: Benefits vs. Risks

**Benefits**
1. High lethality attempt or attempt with clear expectation of death
2. Estimation of suicide risk level: Suicide risk outweighs risk of inappropriate hospitalization
3. Limited capacity of person to follow through on crisis plan
4. Insufficient available support system
5. Inability to restrict access to lethal means
6. Most likely to be beneficial in situations of high acute risk (less if high chronic risk)
7. Hospital time can allow for thorough evaluation, medication adjustments, decrease future suicidal behaviors (for pt's who find hospitalization adverse)

**Risks**
Youth at highest risk for suicide attempt during 1st 2 weeks after being released from psychiatric hospital (Cyz, Liu & King, 2012)

The Importance of Means Reduction

- Many suicide attempts occur with little planning during a short-term crisis.
- Intent isn’t all that determines whether an attempter lives or dies; means also matter.
- 90% of attempters who survive do NOT go on to die by suicide later.
- Access to firearms is a risk factor for suicide.
- Firearms used in youth suicide usually belong to a parent.
- Reducing access to lethal means saves lives.

Reminder: Consult! Document!

1. Remember your protocol –
2. Consultation –
   - For all providers, all levels of expertise
3. Document –
   - Detailed
   - Include quotes, observations of behavior
   - Copy of safety plan or document inability of patient to engage in process

Interactive Practice – Suicide screen, assessment, documentation and safety plan

1. Please pair up
2. One person will be the provider
3. One person will be the teenage patient
4. Goal: Practice asking & completing the C-SSSR suicide screen
5. If you have time, write a safety plan
6. After 10 minutes we will switch
7. Case study – Kelly
8. Following the group work, we will pass out a completed C-SSSR assessment/treatment plan for each scenario

Case Study: Kelly

- Kelly – Read the additional suicide intent information for Kelly. Be creative and act the role as Kelly but not too “teenage like” in that you don’t ever answer or share information. Goal is for providers to practice and enhance comfort level with asking about suicide.
- Provider – Read the C-SSSR, then practice asking Kelly the C-SSSR questions.
  - If you have time, practice determining the suicide risk: low, moderate, severe
  - If you have time, practice writing a safety plan with Kelly
Summary Key Points

- Check yourself first – deep breaths!
- Ask suicide questions directly
- Learn crisis protocols and local resources
- Suicide is a significant, preventable pediatric health condition
- Understanding risk factors, including bullying, mood disorders, substance abuse, and psychosis, is important in assessing risk
- Careful risk documentation is critical
- Work as a team – get consultation

THANKS FOR YOUR PARTICIPATION!

References

Sample EMR documentation

RESOURCES

Suicide Resources
- Know the Signs: http://www.suicideispreventable.org/
- SAHMSA: Suicide prevention: https://www.samhsa.gov/suicide-prevention
- Suicide Prevention Resource Center: http://www.sprc.org/about-suicide
- Primary Care Safety Plan: http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians
- http://www.youthsuicideawareness.org/
- http://www.eachmindmatters.org/
- http://www.sptsusa.org/educators/

MY3 Suicide Prevention Mobile App

Reachout.com

https://www.suicideispreventable.org/
The National Suicide Prevention Lifeline is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress.

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Lifeline Crisis Chat: www.suicidepreventionlifeline.org (available 24/7)

Need help now? Text "START" to 741-741.

The State Information pages of the Suicide Prevention Resource Center Web site list State policies on suicide prevention in schools.

http://www.sprc.org/states/california

POP CULTURE & SUICIDE

Research has shown a link between certain kinds of suicide-related media coverage and increases in suicide deaths. Suicide contagion has been observed when:

- The number of stories about individual suicides increases,
- A particular death is reported in great detail,
- The coverage of a suicide death is prominently featured in a media outlet, or
- When headlines about specific deaths are framed dramatically (e.g., "Bullied Gay Teen Commits Suicide By Jumping From Bridge").

Research also shows that suicide contagion can be avoided when the media report on suicide responsibly, such as by following the steps outlined in "Recommendations for Reporting on Suicide" at www.reportingonsuicide.org.

Contagion can also play a role in cases of self-harm behavior. These behaviors may originate with one student and can spread to other students through imitation. Because adolescents are especially vulnerable to the risk of contagion, it is important to memorialize the student in a way that does not inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying mental health issues such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

However, schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student’s family and friends. Refer to the American Foundation for Suicide Prevention’s "A Era Suicide" resource listed in the Resources section for sample notification statements, sample media statements, and other model language.

Finally, after a death by suicide it is important for schools to encourage parents/guardians to monitor their child’s social networking pages. Students often turn to social networking websites as an outlet for communicating information and for expressing their thoughts and feelings about the death. Parents/guardians should be advised to monitor the websites for warning signs of suicidal behavior.

Family/pt education:

How coach parents about communication

- Talk in a calm, non-accusatory manner
- Let them know you love and care
- Convey how important they are to you
- Focus on concern for their well-being
- Make statements that convey you have empathy for their stress
- Encourage seeking professional help
- Reassure them that they will not feel like this forever by utilizing appropriate help.
Other quick tips

- Prioritize interacting with them in positive ways
- Increase their involvement in positive experiences
- Monitor appropriately your child’s whereabouts and communications (i.e., texting, Facebook, Twitter) with the goal of keeping them safe
- Talk with your child about your concerns and ask directly about suicidal thoughts
- Explain value of therapy and potential for medication management of symptoms
- Address your concerns with other important adults in your child’s life
- Discuss concerns with your child’s doctor to get appropriate mental health referral
- Talk with people in the school who can provide support and guidance
- SEEK PROFESSIONAL HELP!

• School psychologists do not recommend viewing by vulnerable youth
• Some good things about the show
  - No single reason for suicide
  - Suicide affects everyone and everyone can help prevent
• The series does not show
  - Mental health can be treated
  - School counselors as helpful
• If the series is watched, have the teen view it with a responsible adult, spend time discussing each episode

http://www.sprc.org/13-reasons-why
• Mild Risk - Suicidal ideation of limited frequency, intensity, duration and specificity. No suicide plans or intent, good self-control, mild dysphoria, few other risk factors & identifiable protective factors including available social support.

• Moderate - Frequent suicidal ideation with limited intensity and duration, some specificity in terms of plans, no intent. Limited dysphoria, good self-control, some risk factors and protective factors, including available social support.

• Severe - Frequent intense and enduring suicidal ideation, specific plans, no subjective intent but some objective markers of intent (i.e. method chosen & accessible, some limited preparatory behavior). Severe dysphoria, impaired self-control, multiple risk factors, few if any protective factors, particularly a lack of social support.

• Extreme - Frequent intense and enduring suicidal ideation, specific plans, clear subjective and objective intent. Severe dysphoria, impaired self-control, many risk factors, minimal protective factors.

Rationale established with personalized treatment plan. We instructed patient and family to contact office or on-call physician promptly should condition worsen or any new symptoms appear and provided on-call telephone numbers. If the patient has any suicidal ideation and a plan with means to accomplish it, proceeded to the nearest emergency room or crisis center.

Family was agreeable with this plan. We reviewed all warning signs and when to bring @FNAME@ to UCSF Crisis Team.

**Taking Care of Myself**, as dictated by @FNAME@:

People I will contact starting with the first person I would go to for help:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information (Phone, Address, Pager, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ***</td>
<td>***</td>
</tr>
<tr>
<td>2. ***</td>
<td>***</td>
</tr>
<tr>
<td>3. ***</td>
<td>***</td>
</tr>
</tbody>
</table>

Activities I can do to help myself when I’m feeling down or worried. How do these help to make me feel better?

<table>
<thead>
<tr>
<th>Activity</th>
<th>How it helps make me feel better</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ***</td>
<td>***</td>
</tr>
<tr>
<td>2. ***</td>
<td>***</td>
</tr>
<tr>
<td>3. ***</td>
<td>***</td>
</tr>
</tbody>
</table>

Activities/situations that get me into trouble and ways I can avoid them or deal with them:

<table>
<thead>
<tr>
<th>Activity/Situation</th>
<th>Ways I can avoid or cope with the activity or situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ***</td>
<td>***</td>
</tr>
<tr>
<td>2. ***</td>
<td>***</td>
</tr>
<tr>
<td>3. ***</td>
<td>***</td>
</tr>
</tbody>
</table>

Places I will call for immediate or emergency help:

<table>
<thead>
<tr>
<th>Place</th>
<th>How to contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SF Suicide Hotline</td>
<td>Main hotline: 415-781-0500</td>
</tr>
<tr>
<td>2. 911</td>
<td>Dial: 9-1-1</td>
</tr>
<tr>
<td>3. ***</td>
<td></td>
</tr>
</tbody>
</table>
Important numbers to put family's phone/contact lists:

- San Francisco Comprehensive Child Crisis Services: 415-970-3800
- San Francisco Suicide Prevention: 415-781-0500
Suicidal ideation
Precipitating event: ***
Suicide plan: ***
Suicide intent (scale of 1 to 10 with 10 most) ***
Frequency & duration & context of suicide ideation: ***

<table>
<thead>
<tr>
<th>Risk factors:</th>
<th>Protective factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health concerns: ***</td>
<td>Strengths: ***</td>
</tr>
<tr>
<td>Substance use: ***</td>
<td>Supports: ***</td>
</tr>
<tr>
<td>Psychosis: ***</td>
<td>Activities/Hobbies: ***</td>
</tr>
<tr>
<td>Past suicide attempts: ***</td>
<td>Friends/Family: ***</td>
</tr>
<tr>
<td>Past suicide ideation: ***</td>
<td>Community/Religion: ***</td>
</tr>
<tr>
<td>Self-harming: ***</td>
<td>School: ***</td>
</tr>
<tr>
<td>Sexual orientation: ***</td>
<td>Self-control: ***</td>
</tr>
<tr>
<td>Trauma: ***</td>
<td>Use of coping skills: ***</td>
</tr>
<tr>
<td>Recent stressors: ***</td>
<td>Future oriented: ***</td>
</tr>
<tr>
<td>Family history of mental illness: ***</td>
<td>Good parent-child communication: ***</td>
</tr>
<tr>
<td>Access to lethal means: ***</td>
<td>Adherence to treatment: ***</td>
</tr>
</tbody>
</table>

Other mental health concerns:
- Depression: {Depression sx:28150::"denies"}
- OCD: {OCD sx:28203::"denies"}
- Mania/psychotic: {Mania sx:28156}
- Separation anxiety: {separation anxiety:28151::"symptoms persisting at least 4 weeks in children and adolescents and typically 6 months or more in adults. The fear, anxiety, or avoidance is persistent, lasting at least 4+ weeks."}
- Social anxiety: {social anxiety:28153::"symptoms cause clinically significant impairment in daily functioning","symptoms have been persistent for 6+ months"}
- Panic: {panic symptoms:28154::"expresses persistent concern about additional panic attacks or their consequences for 1+ month","pt undergoes significant maladaptive changes in behavior related to the attacks"}
- Generalized anxiety: {GAD sx:28155}
- Specific phobia: {specific phobia:28152::"causes clinically significant distress or impairment in daily functioning"}
- Somatic: {Somatic sx:28204::"denies"}
- Hyperactivity/Impulsivity: {Sx ADHD-Hyperactivity:28142}
- inattention: {Sx ADHD-Inattention:28141}

Impact on daily functioning reported as: {PSY CAP DESCR PHQ IMPACT:29061::"Not difficult at all"}

Prior evaluation and treatment: {none:18576}

Previous medication trials: {none:18576}

Other:
- Sleep concerns: {insomnia sx:28202::"adequate, restful sleep"}
- Appetite/nutrition concerns: {Nutrition:21447::"good appetite"}
- Exercise type/frequency: {aerobic exercise:28296::"Active, healthy lifestyle"}
**Incident**

Did the aggression result in injury to others?
Was a weapon ever used in the violence?
In what context or settings did the violence occur?
What was the client’s perception of the precipitants?
What was the client thinking/feeling at the time of these incidents?
During the incident, was the client using drugs or alcohol?
Have drugs or alcohol precipitated other incidents?
Was the client experiencing psychotic symptoms, such as delusions or hallucinations?
Was the client prescribed medication at the time of the most recent incident? Was @HE@ taking the medication?
What about other incidents?
Who was the victim or target of recent violence? What about other incidents?
What is the relationship of the victim(s) to the client?
What is the purpose/meaning of the violence?
Does the client see any pattern to episodes of violence?
Can the client identify any cues as to when he/she might become violent?
Have there been incidents in which the client was close to violence, or seriously considered but refrained? If so, what helped to prevent the violence behavior?
What responses would the patient suggest to prevent future violence?

**Historical Factors**

- History of violence & delinquency: {hx violence & delinquency:29922}
- Victim of maltreatment/abuse: {hx abuse:20832}
- Home/family maladjustment: ***

Clinical Factor: {clinical factors violence:29921}

Contextual Factors: {violent contextual factors:29919}

Student's motives/goals: ***

Communications surrounding ideas or intent to attach inappropriate interest in: {inappropriate interests:29920}