



Risk - Benefit Analysis Documentation Examples

Providers often weigh the risks and benefits associated with different treatment options when working with individuals at risk for suicide. VA Suicide Risk Management Consultation Program (SRM) consultants recommend that providers thoroughly document this decision-making in the health record. Below are examples of what this documentation might look like. For further support around risk-benefit analysis and documentation, email srmconsult@va.gov.

Example 1

Veteran is considered to be at intermediate acute risk for suicide and is not amenable to voluntary hospitalization. I have considered the potential benefits and risks of involuntary hospitalization. The potential benefit is that it could afford the Veteran the opportunity to rest and get a break from his psychosocial stressors. The risk, however, is that involuntary hospitalization would likely result in a very significant rupture in the therapeutic relationship, a relationship which Veteran has said has been the sole reason for not killing himself in the past. This rupture could heighten his acute risk following hospitalization as well as chronic risk if it negatively impacted future help-seeking behavior. Additionally, hospitalization would amplify one of the drivers of his suicide risk, which is financial concerns as he would have to cancel and potentially lose clients. One of his strongest protective factors is the value he finds in his work and helping others. Removing this protective factor, even if temporarily, could do more harm than good. Given these factors, I believe that the potential risk of involuntary hospitalization outweighs the potential benefits. This assessment occurred in the context of recently improved sleep and his history of being able to navigate situations with his wife so that he can take "time outs" and stay elsewhere if needed. We collaboratively determined a plan for risk management and Veteran agreed to meet weekly for therapy with an additional telephone contact prior to each weekend. I will continue to evaluate risk during these upcoming contacts. Following our session, I consulted with a colleague who concurred with my assessment and plan.

Example 2

While the Veteran experiences chronic suicidal ideation, the current degree of suicidal ideation appears to be above baseline (e.g., suicidal ideation is increasing in frequency and intensity, occurring daily and lasting 1-2 hours instead of fleeting ideation every couple of days), and suggests a relative increase in acute risk, now intermediate acute risk. However, Veteran is not willing and is opposed to a voluntary admission. While Veteran acknowledges increased suicidal ideation, and associated risk, she has also worked on updating her safety plan, has agreed to check in by phone briefly in the next few days, and has identified some important reasons for living and reasons for staying out of the hospital: children and a new job. Veteran also engaged in a lethal means safety discussion and has agreed to dispose of old and expired medication and keep her current medication in a lock box. Additionally, Veteran has endured many similar crises in the past, maintaining safety independently, and outside of the inpatient setting. Involuntary admission would not likely benefit the Veteran in terms of long-term risk management, and potentially comes at the risk of jeopardizing a collaborative therapeutic relationship (due to an unwanted admission). Risk-benefit analysis thus supports continuing



with outpatient care, with the renewed safety plan, increased follow-up, and on-going reassessment.

Example 3

Conducted a risk-benefit analysis regarding changing the current approach to engaging with this Veteran. Our current efforts to engage this Veteran in outpatient mental health treatment haven't resulted in increased appointment attendance or a therapeutic relationship and have potentially reinforced therapy interfering behaviors. The Veteran only initiates phone contacts while intoxicated which interferes with conducting a meaningful risk assessment and prevents the Veteran from utilizing evidence-based therapies appropriately (e.g., treatment for PTSD). This approach has not been successful in addressing the Veteran's chronic risk for suicide or mental health symptoms (e.g., substance use, PTSD, etc.). In an effort to engage the Veteran, our team will change the approach to include brief outreach contacts to encourage attending outpatient mental health appointments. As indicated, these contacts may include a suicide risk assessment to ensure that the Veteran's acute risk for suicide is at baseline. Similarly, contacts initiated by the Veteran, outside of crisis, will be brief and reinforce the importance of scheduling and attending appointments. The team will make an effort to transparently communicate this plan and rationale to the Veteran. The treatment team considered the possibility that the Veteran may present with increased crises as a result of limit setting in the short term, however, believes that this plan has the potential to benefit both the Veteran by establishing a more productive therapeutic relationship through which to address the Veteran's current mental health symptoms and mitigate chronic risk for suicide.