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. The Suicide Risk Management Consultation Program (SRM) consultants recommend that providers thoroughly document this decision-making in the medical 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

In developing the plan regarding the best way to maintain the Veteran's safety, I considered the assessment of him being at moderate acute risk and weighed the potential benefits and risks of involuntary hospitalization as the Veteran is not amenable to voluntary hospitalization. The potential benefit of hospitalization would be 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, in the context of his history of being able to navigate situations with his wife so that he can take "time outs" as well as stay elsewhere if needed, improved sleep over the last two nights, and plan documented above left me feeling that the best course of action was for the Veteran to remain outpatient with increased frequency of contact and assessment. 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, and suggests a relative increase in acute risk, now moderate acute risk. However, Veteran is not willing to pursue voluntary admission, and is quite opposed to such. While Veteran openly 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). Additionally, Veteran has endured many similar crises in the past, maintaining safety independently, and outside of the inpatient setting. Involuntary admission thus seems unlikely to offer much benefit in terms of long-term risk/management, but potentially comes at the cost 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 and increased follow-up, and on-going reassessment.

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Example 3

Risk-benefit analysis supports altering the current approach to engaging with this Veteran. Current efforts and standard outreach protocols have failed to result in a gainful therapeutic relationship, and have arguably positively reinforced therapy interfering behaviors, whereby the Veteran only engages in contacts (e.g., telephone contacts while intoxicated) that do not afford the opportunity to conduct meaningful assessment (for diagnosis and/or risk), or to deploy evidence-based therapies appropriate for such. This approach has not afforded any benefit in terms of the Veteran's chronic risk for suicide, or mental health well-being more generally. Hence, an alternative approach seems justified. In an effort to facilitate therapeutically oriented engagement, out-reach calls will be limited (in number and duration) to brief contacts to emphasize our ability and willingness to offer treatment in the context of scheduling and attending appointments. As indicated, these contacts may include a suicide risk assessment to ensure that the Veteran's acute and chronic risk for suicide are at baseline. Similarly, contacts initiated by the Veteran, outside of crisis, will be brief and involve the provision of similar information emphasizing the importance of scheduling and attending appointments. We will make an effort to advise the Veteran of this plan, transparently communicating the need to help him to transition his manner of engagement into one which may potentially allow for the provision of appropriate care, including ongoing risk assessment, and the lack of apparent therapeutic benefit associated with our current approach. This discussion/analysis has been shared among the treatment team, and the consensus opinion is that altering our contacts in the manner described affords the best chance of engaging Vet in care and mitigating his risk in the long-term.