APPENDIX G: Sample Risk Assessment Documentation

These notes provide a sample of the content that comprise a comprehensive suicide risk assessment. While abbreviations and succinct writing can shorten them, they are presented to demonstrate the type of documentation that is recommended. The Suicide Status Form (SSF) and SF600 overprint in this guide can provide alternative means for documenting this clinical content.

A. From an Intake Note

Suicide/Homicide Risk Assessment:

Precipitant: The patient's recent suicide attempt (overdose with aspirin) was precipitated by the breakup of his five-year marriage and separation from his two children (ages 5 and 7). Details of the attempt are noted below. The couple is currently separated and the patient has limited weekly-supervised contact with his children.

Static Factors: His past history is positive for one suicide attempt without injury, an overdose attempt (aspirin) at the age of 16. The patient expressed subjective intent to die at the time, but there were no objective markers of intent. The number of aspirin taken was small and the lethality very limited (reported at "about ten"). The patient noted that he took them "in front of his parents" who immediately took him to the emergency room. No medical care was required and he was released to his parents' supervision after a brief evaluation. Although follow-up psychological care was recommended, he did not follow through. There was no evidence of any preparatory, planning, or rehearsal behavior of any type. Additionally, he added that he was "glad that he didn't really hurt himself". The patient reported that the first suicide attempt was "impulsive" and motivated by "anger" at his parents for "grounding him". He denied any alcohol or substance abuse of any type at the time, with no evidence of cognitive impairment. There is no reported history of abuse of any type (physical, sexual, emotional) and no reported history of diagnosed psychiatric illness or treatment.

Aggravating Factors: As noted above, the patient overdosed on a "handful of aspirin". The attempt required no medical care although he was taken to the emergency room. He was evaluated and released to home, with scheduled outpatient follow-up. The patient reported subjective intent to die but there were no objective markers of intent. The patient took the overdose "in front of his wife", reports that he was again "being impulsive", with no associated preparatory, planning, or rehearsal behaviors of any type. At present, the patient reported no suicidal thoughts whatsoever, intent, or plans of any type. He also reported no access to a method, with all medications having been removed from the home. This was confirmed with a family member (see signed release form). Prior to the attempt, the patient denied any significant suicidal ideation, noting episodic thoughts the week prior that would endure for "a few seconds". Accordingly, he rated the severity of his suicidal ideation as a 1 on a 1 (none) to 10 (severe) scale. When asked about reasons for living/dying, the patient stated that he "lives for his kids" and "wouldn't kill himself because it would hurt them too much". He denied any prominent symptoms of any type and also denied any substance abuse of any type (current or previous). There was no additional evidence of substance abuse or associated cognitive impairment. He rated depressive and anxiety symptoms both as a 1 on a 1 (none) to 10 (severe) scale. He reported that he was hopeful about the future, despite his pending divorce, scoring a 2 on a 1 (hopeful) to 10 (hopeless) scale of hopelessness. Previously identified cognitive themes for

hopelessness include: unlovability and poor distress tolerance. Although the patient denies being impulsive, there is clear objective evidence of impulsivity related to the two previous suicide attempts. There is no evidence of associated instrumental behavior.

Chronic Risk: There is no current evidence to suggest that the patient is at chronic risk.
Acute Risk: Current risk is estimated as minimal.
Suicidality Management Plan:
1. The patient will initiate individual psychotherapy and concurrent marital therapy to address separation.
2. Current symptom severity is not adequate to warrant referral for medication evaluation, nor does the patient want such a referral.
3. The patient has signed a commitment to treatment statement, see attached.
4. The patient has demonstrated the ability to, and has agreed to make use of, his crisis response plan, see attached.

B. From a Follow-up Note

Suicide/Homicide Risk Assessment:
Precipitant: The patient continues to experience significant marital distress but is actively engaged in marital therapy.
Static Factors: Noted in previous entry (at intake).
Aggravating Factors: The patient reports no active suicidal thoughts (rating of 1) and no related intent, plans, or behaviors. There have been no additional attempts since last session, with no current access to medications. Symptom reports are unchanged from last session. He reported that he was hopeful about the future, scoring a 1 on a 1 (hopeful) to 10 (hopeless) scale of hopelessness. Previously identified cognitive themes for hopelessness include: unlovability and poor distress tolerance and are actively being addressed. No evidence of impulsive or instrumental behavior since last session.
Chronic Risk: There is no current evidence to suggest that the patient is at chronic risk.
Acute Risk: Current risk is estimated as minimal.
Suicidality Management Plan:
1. The patient will continue in individual psychotherapy and concurrent marital therapy to address separation.
2. No current symptoms and no indicated need for a medication referral.
3. The patient has signed a commitment to treatment statement and is in compliance.
4. The patient has demonstrated the ability to, and has agreed to make use of, his crisis response plan, see attached.