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The assessment of suicide risk requires a careful evaluation of the patient, a thorough collection of the relevant data, and the exercise of good clinical judgment. The Suicide Assessment Template is designed to help the clinician with this task by recording the data necessary for such an assessment of suicide risk in one place, and have this information available for all clinicians who work with the veteran at risk. Filling out this form is an aid to clinical judgment, not a replacement for it. However, adequate documentation of the evaluation of risk can only help in decision making and help to reduce medico-legal risk. In addition, we will undertake an ongoing evaluation of the utility of this risk assessment for enhancing patient safety.

The Risk Assessment Template has been designed and reviewed by the VISN 3 Suicide Assessment Workgroup after a thorough review of the literature. We offer the evidence base for each segment of this tool. The references will be based on five papers that comprehensively review the relevant literature, some of which also report on original research.

1. Mann, Waternaux, et al., “Toward a Clinical Model of Suicidal Behavior in Psychiatric Patients,” American J of Psychiatry 156:2, February 1999, 181-9

2. Fawcett, Scheftner, et al., “Time-Related Predictors of Suicide in Major Affective Disorder,” American J of Psychiatry 147:9, September 1990, 1189-94

3. Hall,et al. “Suicide Risk Assessment: A review of Risk Factors for Suicide in 100 Patients Who Made Severe Suicide Attempts” Psycosomatics 40:1, February 1999. 18-27

4. US Preventive Services Task Force, “Screening for Suicide Risk”. http://www.vnh.org/GCPS2/60.html

5. Tondo and Baldessarini, “Suicide: An Overview”. http://www.medscape.com/Medscape/psychiatry/ClinicalMgmt/CM.v03/pnt-CM.v03.html

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Patient Information:

Current Suicidal Ideation/Intent/Plan: (patient may be at risk for suicide without voicing ideation, intent or plan)

Ideation yes [ ] no [ ]

{if yes to ideation then the options of passive or active will appear, and the positives will be checked off and described. For a yes at least one would need to be checked but both could be applicable}

Passive yes [ ] no [ ]
Active yes [ ] no [ ]

Intent yes [ ] no [ ]
Plan yes [ ] no [ ]

Describe: *free text required*

[NO's will be included in the note generated from template]

Suicidal ideation is the usual starting point for thinking about suicide risk, and correlates with acute, short term (within 1 year) and longer term (2-10 year) risk (1,2,5). Passive suicidal ideation is synonymous with the wish to die. Patients will express that they wish they were dead, others would be better off if they were dead, but do not express a desire or intent to do anything about these thoughts. Active suicidal ideation refers to the patient having thought about killing her or himself. They may even thought about how they might do it, but we do not score a patient positive on having a plan until they have begun to take steps towards making their ideas about how they might do it available to to themselves. This may actually having the means in their possession or it may entail having a clear and practicable series of steps for acquisition of means and implementation of "plan". However lack of suicidal ideation is quite frequent in suicide attempters, and on psychological autopsies of completed suicides, no suicidal ideation, or only indirect expression of SI is a frequent finding (1,2,4,5). Intent and plan will generally increase our suspicion of the immanent risk of suicide in a given individual but generally does not correlate as well with overall suicide risk (1-5). Measures of intent and plan include the preparations and leave-takings sometimes seen as individuals put their affairs in order in anticipation of suicide, even without overt expression of intent.

Longstanding, Chronic Risk Factors: *these factors place the person at an increased risk for suicidal behavior. They are relatively immutable trait type characteristics (the exception being an illness that enters remission)*

These risk factors are essentially additive. A patient with any single one of these characteristics may be at higher risk for suicide than the general population, but is not necessarily a chronic high risk for suicide (the exception to this being previous suicide attempts). Most clinicians become more concerned with the level of risk as the patient accumulates a higher number of risk factors. For example, the greater the number of comorbidities, the higher our degree of concern. This becomes more pronounced as patients demonstrate risk factors in several categories.

It is possible that someone with only 1 or 2 longstanding factors will be of great concern for suicide (e.g. a patient with severe psychotic depression, who then demonstrates multiple acute factors), while a patient with multiple factors will be of less concern (e.g. a veteran with schizophrenia and substance abuse, and history of violence, currently smoking, but sober for a year, adherent with treatment, with one or two good supports, a stable housing situation, and work or day program that patient feels good about), but these situations are less common.

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It is theoretically possible for a patient to be a suicide risk in the absence of any longstanding risk factors, but psychological autopsy data suggests that this is a very unlikely scenario.

Previous Suicide Attempts: (describe circumstances, stressors and means of previous suicide attempts, in particular the details of the most recent attempt prior to the current one, including response to treatment interventions) *free text required*

This is the single most significant actuarial factor in the prediction of suicidal behavior and suicide risk. The more severe and violent the suicide attempt the higher risk we assign to subsequent behavior. A suicide attempt is an action dangerous to oneself accompanied by an intent to die. It counts even if we, as professionals, do not consider the attempt to be medically lethal. While a significant number of completed suicides occur on the first attempt, suicide attempters do go on to become completers with relatively high frequency(1-5). Collecting the data about previous attempts is important both for assessment of risk and for treatment planning.
An important element in treatment planning is to attempt to evaluate suicide attempts in terms of escape behaviors vs. operant behaviors. Escape behavior is the coupling of the suicide attempt to the need to end overwhelming pain from the symptoms and circumstances the patient is experiencing. Operant behavior is when the suicide attempt appears to be used to cause change or response in the environment. Frequently elements of both will appear, but they may lead to different interventions, and different attitudes amongst treating clinicians.
There is an overlap between this section and the section on Personal Risk Factors below, since many individuals require a constellation of factors to become suicidal, and the particular set of symptoms and circumstances can be quite idiosyncratic.

Impulsivity:	**Violence**	**yes [ ]**	**no [ ]**
	Verbal Aggression	yes [ ]	no [ ]
	Head Injury	yes [ ]	no [ ]
	Smoking	yes [ ]	no [ ]
	Impulsive behaviors	yes [ ]	no [ ]

Describe: *free text required for positives*
[NO's will be included in the note generated from template]

Impulsivity can not be underestimated as a contributor to suicide risk (1-5). The impulsive/aggressive factor correlates with both acute and longer term risk (1). The above list is symptoms that correlate with impulsivity. Violence and verbal aggression (1-5), are the most significant on this list. Head injury is an actuarial factor associated with increased suicide risk, probably through its impact on impulsivity (1) and smoking is also a correlate (1), although it is possible that both of these affect impulsivity through alterations in serotonergic function. "Impulsive behaviors" is a broad category, which allows clinicians to assess impulsivity in variety of ways. The first is by diagnosis and behaviors. Cluster B personality disorder as well as substance abuse diagnoses correlate with impulsivity. Substance use is a sign of impulsivity, even if subthreshold for an abuse or dependence disorder. Gambling, bulimia, kleptomania are all impulse control disorders. Some sexual disorders, and paraphilias are another group of impulsive behaviors, which in and of themselves do not have a high correlation with suicidal behavior, but may be significant with the presence of other factors. Absence of all these factors does not prove absence of impulsivity, but is a fairly good approximation.
The other method for looking at impulsivity is to use questions from an impulsivity scale, the most well accepted being Barrett's. These scales generally ask questions about the immediate need to act, restlessness, blurting out, impatience, instant gratification versus the ability to think and assess consequences before acting, and ability to delay gratification.

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Illness: [ ]Depression [ ] Substance Abuse
[ ] Psychosis [ ] Alcohol Abuse
[ ]Bipolar Disorder [ ] Serious medical Illness
[ ]Cluster B personality [ ] Pain

Describe: *specify, free text optional except for serious medical illness which should be described.*
[only positives will be incorporated in note]

Each of these diagnostic categories are associated with an increased incidence of suicide (1-5). 80% of suicides occur in individuals who fall into one of these categories, diagnosed or undiagnosed during the course of their lifetimes (4,5). However most individuals with any of these diagnoses do not kill themselves, so mental illness and substance abuse are actuarial risk factors. Cluster B Personality Disorder is the group of personality disorders in DSM-IV, which are strongly correlated with the traits of aggressive impulsivity and affective instability. They are Borderline Personality disorder, Anti-Social Personality Disorder, Narcissistic Personality Disorder, and Histrionic Personality Disorder. Serious medical illness is both an actuarial risk factor, but often correlated with more acute risk, especially when new onset, worsening course, or when treatment options have been exhausted (2-5). Illnesses where chronic pain is a factor can significantly contribute to suicide risk.

Acute Factors: *these are factors that place a person in a more acute risk of suicide. They are not as longstanding, tend to be more mutable, and are targets for treatment. When identified in a person at risk, the treatment plan should describe how these factors will be addressed.*

In clinical situations we again tend to increase our concern when there are a greater number of these factors present. In particular when these factors are associated with an illness of which they are not necessarily a predominant feature, or if they dominate the clinical picture of a particular disorder, or if they are of particularly high intensity, our concern increases. It is possible, although unlikely that an individual could be highly symptomatic, but not meet criteria for any psychiatric illness (e.g. person with chronic pain, multiple acute risk symptoms, psychosocial disruption and poor supports, in possession of a fire arm, but no previous psychiatric diagnosis, minimal impulsivity if any, and no previous suicide attempts, might rise to significant concern in suicidal risk). It is more likely that they could be highly symptomatic but have not received any psychiatric diagnosis.
The greater the number in a given category the greater the clinical concern, and the greater the number of categories identified the greater the clinical concern.

Symptoms:

psychic anxiety	yes [ ]	no [ ]
panic	yes [ ]	no [ ]
hopelessness/demoralization	yes [ ]	no [ ]
insomnia	yes [ ]	no [ ]
obsessionality	yes [ ]	no [ ]
alcohol use	yes [ ]	no [ ]
hallucinations	yes [ ]	no [ ]
pain	yes [ ]	no [ ]

Describe: *free text for all yes responses*
[NO's will be included in the note generated from template]

These are the symptoms that are most consistently identified as increasing the acute risk of suicide (1,2,3 and 4,5). Psychic anxiety is the subjective feeling of anxiety and distress. It is anxiety as a symptom and not necessarily the disorder. Panic also refers

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to the symptom not the disorder. Alcohol use refers to intoxication, not necessarily an alcohol abuse or dependence. Hopelessness/demoralization is the expression of loss of expectation for improvement, alleviation and/or control over situation and suffering, and increases both acute and longer term risk (1,2 and 3). Obsessionality increases risk in patients with affective disorder (2,5). Hallucinations of any kind increase the risk of suicide, particularly earlier in the course of psychotic illness and exacerbations; the difference between hallucinations and command hallucinations in terms of suicide risk are frequently overestimated (5).
This list of symptoms correlates with the notion of "psychache" or acute psychic pain, and has been validated in psychological autopsies of completed suicides and medically lethal suicide attempts. Of note here is the absence of depressed mood in the list. This is because depressed mood seems to be most significant as a factor in the presence of demoralization and hopelessness.

Social: check all that apply

[ ] Poor Social Support [ ] Isolation
[ ]Environmental change [ ] Recent discharge
[ ] Recent loss [ ] Acute life stressors
[ ] Family history of suicide

Describe: *free text required if positive responses.*

An acute risk factor for suicide is the occurrence of stressful life events, the list above being the most common (1-5). Losses and stressors can include anything significant including bereavements, loss of relationship, employment, housing, economic hardship. Individuals have become suicidal over the loss of a pet. Family history of suicide is an actuarial risk factor.
Any of these events in which humiliation and shame are part of the experience are of particular significance in the suicide assessment.

Medication Factors: [ ] adherence to medication
yes [ ] no [ ]
[ ] recent Lithium withdrawal
[ ] recent medication change
[ ] pain management (where applicable)

Describe: *free text required*

Patients nonadherent with medication are at increased risk, since nonadherence prevents treating the symptoms or illnesses placing the individual at risk, and indicates problems in the therapeutic alliance. In addition, nonadherence can reveal patients stockpiling of medications as a means for a suicide attempt. Recent Lithium withdrawal in Bipolar individuals increases risk of suicide at least fivefold (5) over 4-6 months (with some estimates in the literature going out to 1 year). There is evidence that lithium responsiveness and clozapine responsiveness are mitigating factors in suicide risk. Patients requiring pain management may be at increased risk because of chronic pain or abuse of pain medications. When a pain patient is not abusing his/her medications, and has had significant relief of symptoms, this will often lead to pain dropping out as a risk and may even become a mitigating factor.

Personal Risk Factors: (particular factors that have triggered previous suicidal behavior or are leading to current suicide risk; may include idiosyncratic circumstances predictive only in this patient. This involves an individualized constellation of factors, usually both chronic factors and a combination of acute factors that have led to current or previous suicidal impulses and/or the attempts described above, if applicable)

Describe: *free text required*

In examining suicidal individuals, researching suicide, and performing psychological autopsies, many patients demonstrate particular circumstances that enhance suicidal

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propensities and behavior. These are peculiar to each individual and may entail particular embarrassments or humiliations, specific types of interactions with particular individuals, some reminder of traumatic experience, whether overt or covert, and many other possibilities. It is these constellations that illuminate the nature of the psychic pain the patient experiences, the circumstances that make it unmanageable and cause suicidal impulses to outweigh the mitigating factors in a person's life. These are the most important factors to elucidate in assessing the risk of the current situation, and for treatment planning, especially if they are amenable to intervention. For the individual with chronic increased risk this cannot be understated.
When we are aware of the personal risk factors, the combination of illness, acute symptoms, environmental changes and stresses and the subjective experience of the combination, we have a readily available checklist for the kind of suffering that the patient is able to bear, and the kind of suffering that crosses the threshold of his/her endurance. It is when the circumstances arise that cross this threshold that our concern for suicide, and vigilance should also increase. That is why the greater the detail we have in regards to previous suicide attempts and/or periods of serious increased ideation the better we are at distinguishing periods of increased suffering from periods of increased suicide risk.
This is also an opportunity to make special mention of **operant suicide attempts**, which often lead to the greatest frustration amongst clinicians. These are the attempts where the patient seems to be attempting to change something in the environment or acquire something from the environment through the suicide attempt. They are often called suicidal gestures. An understanding of the circumstances that lead to these acts, and particularly the desired responses from the environment both proximal and distal are paramount in being able to intervene therapeutically and appropriately with these type of attempts. It is also the best way to avoid confrontational escalation of the situation.

Firearms: Currently Available yes [ ] no [ ]
Removed yes [ ] no [ ]
Describe: *free text required*
[NO's will be included in the note generated from template]

The most common means for completing suicide in the United States for both men and women, and the environmental factor that most increases the risk of completed suicide (2,4,5). While all guns have a huge impact on the odds ratio for suicide, handguns tend to have even more risk than rifles.
Ideally when we speak about removal of means it means that the patient would give up the gun and no longer have access to a weapon, this is often not practical with many of veterans, for whom guns have special meaning or are a source of recreation, or an economic necessity (e.g., hunting). Removal of means my therefore mean any steps which impede the use of gun for suicide, particularly for impulsive acts. Giving the gun to a relative, locking it in a gun case/cabinet and giving the key to some one else, trigger locks, giving the ammunition to a friend, relative or hunting partner.
Acquiring agreement towards these steps of removing the weapon is also a good beginning and indicator of the treatment alliance, and the first step towards the treatment plan.

Access to other Means: Currently Available yes [ ] no [ ]
Removed yes [ ] no [ ]
Describe: *free text required*
[NO's will be included in the note generated from template]

Other methods, while not as dangerous as firearms, when available increase the risk. This is particularly true when patients have a plan with available means, or have their preferred means available and are highly impulsive. In regards to removal of means, see discussion in firearms section.

<table>
<tr><td>Mitigating Factors: (alternatives to suicide, plans and hopes for future, beliefs supportive of continued living, religious beliefs, reasons to continue living, dependant children, psychic toughness, other)
Describe: free text required</td></tr>
<tr><td>These are all the factors that diminish the risk of patients acting on suicidal feelings or impulses, or of reaching the level of suicidal behavior in the face of high risk symptoms, diagnoses, and circumstances. None are absolute and must be judged against the circumstances contributing to risk. Included in mitigating factors are good relationship with caregiver, a good therapeutic alliance, intact social supports, problem solving and coping skills, and awareness that suicide is a product of an illness (2,4,5)
Psychic Toughness is best defined as the demonstrated lifelong resiliency to pain, stress, discomfort and the problems of life. It refers to those who can take the difficulties, usually manage them and continue functioning. It also refers to the capacity to endure distressing experiences and circumstances, as well as the quantity of intense affect a person can bear. This resiliency is both a general capacity for enduring and bearing pain and tumult, but can also be specific. An individual may have a high capacity for certain types of distress and a lower threshold for others.</td></tr>
<tr><td>Category of Risk: (the first check off is if there are acute factors, identified above, currently active that need to be addressed)
[ ] Acute Factors Current
(the next two categories refer predominantly to the long-term or diathesis type risk, rather than aspects of more acute suicide risk)
[ ] Baseline Increased Risk
[ ] Limited risk</td></tr>
<tr><td>There is no fixed formula for determining the level of suicide risk and this evaluation requires good clinical judgment. Generally it is related to the level of pain the individual is in, that individual’s ability to bear the pain, while finding ways to solve or endure the problems (symptoms and circumstances) leading to the current state, without attempting to end the pain by ending one’s life. Like physical pain, psychic pain does not follow a pure lesion model; symptoms and stressors that are unendurable for one patient may be quite endurable for another.
Roughly the level of suicide risk is proportional to the amount of distress from the patients psychiatric symptoms and distress from environmental, psychological and social stressors, and inversely proportional to the ability to endure those stressors, and the mitigating factors.
This is the stress aspect. The diathesis is the factors that make it less likely that the person will be able to endure the stressors of life. These are the risk factors of the psychiatric illnesses listed above, the trait of aggressive impulsivity and behaviors associated with this, a history of previous suicide attempts, and a family history of suicide.
The diathesis factors are relatively immutable and are facts of the patients’ life. A psychiatric diagnosis plus any of the other factors places a patient in a chronic high risk category. The psychiatric diagnosis itself, particularly if the patient remains symptomatic, or if any acute factors are present, may be enough for a clinician to make the judgment that a patient is a chronic high risk. It is important to note that the psychiatric diagnosis, despite being a longstanding issue is mutable; adequate treatment may place the illness in complete remission. For a patient in complete remission of their psychiatric syndrome, it can be appropriate to lower their chronic risk level. Such a remission frequently strengthens the patient’s therapeutic alliance, hopefulness, and of course, diminishes their psychic pain.
The assessment has two tasks. The first is to help in identifying those patients who are chronic high risk individuals. The second is to help identify those individuals developing</td></tr>
</table>

a clinical picture that places them more acutely at risk. This is where the presence of acute factors occur within the setting of the presence of diathesis or chronic factors. The greater the number and severity of the acute factors and the lesser the number and strength of the mitigating factors the higher the risk. This is a complex and subtle clinical judgment, and management is geared towards enhancing the mitigating factors and ameliorating the acute factors, as well as treating the diathesis factors as assertively as possible.

Some patients that are acutely high risk, communicate directly or indirectly that they are suicidal right now. The goal of treatment is immediate containment and relief of the most acute factors. Containment may require hospitalization, but with cooperation from patient, family, significant others, and or staff, frequently hospitalization can be avoided. In general, managing suicidality in the community wherever possible is a more efficacious way of addressing the acute and chronic factors that drive the suicidal behavior.

Acute Factors Current: This concretely identifies those patients where there are active and current Acute Risk Factors affecting the clinical picture. As a clinician does the suicide risk assessment, it will become clear which patients endorse enough acute risk factors (and frequently longstanding factors as well) that they create significant near term concern in regards to their potential suicidality. At that instant the clinician will initiate treatment, and interventions designed to ameliorate and contain the patient's suicide risk, by addressing those factors, biological, psychological or social that enhance the risk. The suicide assessment helps collect and document the targets for such intervention.

Baseline Increased Risk is related to the diathesis factors described above. Management involves the assertive treatment of the psychiatric disorder, and sensitivity to any new emergence of acute risk factors or disruption in mitigating factors. There is no algorithm or formula for deciding when a patient is in this category. Having previous suicide attempts generally will place a person in this category. Having a serious mental illness or a substance disorder does not automatically place one in this category. Having a high level of impulsivity does not automatically place on in this category. Having both a serious illness and a high level of impulsivity, along with any other factors is likely to place an individual in this category. It is important to be vigilant about follow-up with veterans in this category: missed appointments should be addressed with immediate phone calls and timely rescheduling. For patients where phone contact fails, alternate means of communication should be utilized wherever possible.

Limited Risk are veterans with some diathesis factors but have not reached the level of concern with suicidality that the chronic high risk veteran has. They may be impulsive or have an illness that puts them at higher than expected risk, but very limited current problems and no previous history of suicide. Another possibility is the history of suicide had low intent, low lethality many years ago, and the patient's current symptoms and illness are fairly stable.

It may also include patients with above diagnoses in remission or recovery. They may be patients where the mitigating factors so outweigh the risk factors that the clinician does not judge them to rise to the level of concern of a chronic high risk individual. This category would also include veterans who have no history of suicide, low impulsivity, well stabilized psychiatric illnesses, and strong mitigating factors.

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Interventions and Plan:
(OVERVIEW:
The goal of a suicide assessment is to then determine how best to prevent suicide as an outcome and as a guide to treatment. The fundamental guidelines for treating suicide are to address the environmental components, address the risk factors for suicide, and to help the patient weather the storm. For most patients, including the chronically suicidal, preventing suicide in the most immanent period usually allows the patient and professional some time to address the other issues. Weathering the storm involves providing adequate containment for the patient's suicidal impulses. This may include hospitalization, but hospitalization is not the only form of containment, nor is it necessarily the best one. It is the last resort when it is the only possible way to keep the patient alive. Hospitalizing a suicidal patient can leave them leaving the hospital with the same problems that brought them in, sometimes even worsened by a hospital stay (financial, stigma, childcare, etc.), so hospitalization should be thought through in terms of the ability to address the problems that lead to the suicidal feelings.
There are many other forms of containment. The simple arranging of continuing care, or a quicker appointment with the patient's mental health provider, or an extra appointment or even phone call can serve as containment when the relationship with the provider is an important stabilizing force. In addition, if the patient has the means available for suicide, but is willing to work with the provider to remove the availability of those means, that can also serve as a form of containment. Sometimes it is necessary to have professionals in the patients living arrangements, families, or significant others involved in the prevention of suicide. This can also be part of working on some of the environmental problems that are feeding the suicidal urges.

There is a subcategory of acute risk that is not specifically addressed and that is the category of immanent risk. Usually these are people with a high baseline increased risk, and a high degree of acute factors, with suicidal intent, and at least means available, if not a plan. These are patients where the confidence in the containment and existence of the mitigating factors should be high to allow the clinician to avoid hospitalization. Many of these patients have a history of previous attempts, and the personal risk factor section of the assessment becomes extremely important in determining if a patient needs hospitalization. Many patients with immanent risk will be hospitalized, but many will not.
Hospitalization does not end the level of containment. For veterans, who in your clinical judgment, are at highest risk, hospitalization may not be enough containment, and they may require 1:1 observation or other special monitoring procedures.)

[] Contact with family/social support made
[] Containment
- [] Family agrees to observe patient
- [] Other social support (e.g. residence staff) agrees to observe patient
- **[] Removal of means**
  - [] Firearms
  - [] Other
- [] Initiate emergency hold:
- [] Admit to inpatient care
- [] Place patient on 1:1 observation

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[] Arrange Continuing Care

[] Arrange Outpatient follow-up:

[_*(textbox) required description of referral* _______________]

[] Patient to be seen within 24 hours.

[_*(textbox) required description of referral* ________ __ _______]

[] New Referrals to

[_*(textbox) required description of referral* ________ __ _______]

Risk Factors Addressed:

(Overview:
In identifying the risk factors the treatment plan now involves treating all those factors that are reversible and or modifiable. It is frequently impossible to address all the risk factors at once so the sequence will rely on the clinicians' judgment, and discerning which of the factors/situations/symptoms/conditions cause the greatest psychic distress. Which are the factors that seem most closely tied to pushing the patient to suicidality? Address those first. For patients with previous attempts, the personal risk factors often provide a guide for the importance of their contribution to suicidality. How does the distress interact with the mitigating factors is another important question.
We are asking you to document that your treatment plan addresses these risk factors, and to provide a rationale for which factors you have chosen to address first. This should provide the patient with the proper treatment as well as documenting the care you put into your decision-making. In addition document the patient's reaction to your treatment recommendations.
We do not have a box for a nonsuicide pact, as these have frequently been found not to be useful, and there utility is generally attributed to the quality of patient-provider relationship. If you choose to use them with your patients you can document it here, but it is not a shortcut for any of the other measures in working with suicidal individuals)

[] Acute Factors Addressed

[] Symptoms

[] Environmental Factors

[] Medication Factors

[] Treatment of Underlying Psychiatric Disorder(s):

[] Medication Change or Adjustment

[] Psychotherapeutic Changes or adjustments

[] Identification of reasons to live/mitigating factors

[] Veteran response to changes

[] Positive

[] Neutral

[] Negatrive

Describe:

The treatment plan should document the steps taken towards ensuring the patients safety, their level of cooperation with these procedures, steps taken towards relieving the factors creating the acute distress. A complete treatment plan involves addressing the acute factors, treating the underlying psychiatric illness, decreasing access to means, enhancing the mitigating factors. For patients who are acutely at risk, these aspects should be addressed immediately with plans for follow-up described. It is impossible to treat everything all at once, so it is reasonable to treat the most important, highest risk and distressing aspects first, and then move on to other issues as patient improves.

It is important to note that Acute factors present for Suicide does not mean hospitalization, but does mean containment. For many patients the arrangement of followup appointments, increased frequency of meetings, along with a variety of environmental interventions serve as containment. Containment is not absolute. It allows the patient/veteran to feel that there are options besides suicide, and able to move forward with those alternatives.