

Therapeutic Risk Management of the Suicidal Patient: Stratifying Risk in Terms of Severity and Temporality

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This column is the third in a series describing a model for therapeutic risk management of the suicidal patient. In the preceding column, we described augmenting clinical suicide risk assessment with structured instruments. In this column, we describe how clinicians can use the totality of available clinical data to offer a two-dimensional risk stratification that qualifies risk in terms of both severity and temporality. By offering two separate designations that reflect severity for both acute and chronic risk, conceptualizing and communicating a patient's risk for suicide is accomplished in a more nuanced way, providing the level of detail necessary when working with high risk individuals, especially those struggling with chronic suicidal ideation. Formulations reflecting suicide risk need to be accurate and facilitate good clinical decision-making in order to optimally balance the principles of autonomy, non-maleficence, and beneficence. Stratifying risk in terms of both severity and temporality helps identify situations in which involuntary hospitalization is warranted, while also helping to minimize unnecessary admissions. Hence, two-dimensional risk stratification that addresses both acute and chronic risk for suicide is an essential component of therapeutic risk management of the suicidal patient. (*Journal of Psychiatric Practice* 2014;20:63-67)

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This is the third column in a series describing the model for therapeutic risk management of the suicidal patient developed at the Veterans Integrated Service Network (VISN) 19 Mental Illness Research, Education and Clinical Center (MIRECC).^{1,2} In the preceding column, we described a combined approach to suicide risk assessment entailing a clinical interview augmented by formal risk assessment measures. We made the case that augmenting the standard practice of clinical risk assessment with the addition of reliable and valid structured meas-

ures facilitates a more nuanced approach to suicide risk assessment. This multifaceted approach not only augments clinical care, but also serves an important medicolegal function, while simultaneously helping to realize the goal of therapeutic risk management of the suicidal patient.² The next step in the process involves utilizing the clinical data obtained via this combined method to arrive at a reasonable approximation regarding the individual's level of current risk for suicide. Such a determination is best accomplished with an approach that stratifies risk in terms of both severity (i.e., low, moderate, high) and temporality (i.e., acute or short-term verses chronic or long-term). Our bi-dimensional approach to suicide risk stratification is described in this column.

Stratifying Risk in Terms of Both Severity and Temporality

In routine clinical practice, suicide risk stratification typically involves the use of a single modifier to denote the perceived severity of suicide risk, with terms like low, medium or intermediate, and high commonly employed for this purpose. Of course,

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estimates regarding the degree of suicide risk ought to inform clinical decision-making, especially as it pertains to the level of care necessary for optimizing patient safety. Risk stratification should, to a large degree, guide important determinations such as whether or not a patient's clinical presentation warrants involuntary hospitalization, or if that individual can remain an outpatient with increased follow-up and a plan to manage safety in place.

Risk stratification should inform clinical decision-making in a manner that appropriately balances the medical ethical principles of autonomy, non-maleficence, and beneficence.³ While it is obviously important to recognize a suicidal crisis and hospitalize a patient who is otherwise not able to maintain his or her own safety, it is also necessary to consider that hospital admission, especially involuntary hospitalization, is not without consequences. An unwanted (and unnecessary) hospitalization may disrupt various psychosocial roles and relationships, such as a needed job or supportive familial bonds, and, in doing so, may actually threaten protective factors that mitigate suicide risk on a long-term basis. From the medicolegal perspective, risk stratification needs to demonstrate a well-reasoned risk assessment process and clinical decision-making that is commensurate with the existing risk and protective factors, and formulations regarding the degree of risk. Our own experience in evaluating and managing patients at high risk for suicide has revealed that one-dimensional stratification, absent any temporal referent (i.e., failing to distinguish between acute versus chronic risk), is too imprecise for accurately capturing the nuances of suicide risk, or for optimally guiding clinical decision-making. One-dimensional stratification may also yield formulations that are medicolegally precarious as a consequence of imprecision. This reality is perhaps best illustrated by a hypothetical clinical scenario.

A 32-year-old female presents to the emergency department with complaints of shortness of breath and chest pain after a near-miss automobile encounter. She makes alarming statements ("I can't take it anymore... I'm done") upon her initial arrival, raising concern for possible suicidal thoughts. Medical work-up is negative. The patient's history of psychiatric illness, involving major depression, posttraumatic stress disorder, substance

abuse, and borderline personality disorder, leads to the formulation that anxiety is the driving force behind her presenting complaints; therefore, psychiatric consultation is requested. On psychiatric evaluation, the patient indicates that she was recently discharged from a local inpatient psychiatric unit (about 4 weeks before this assessment), and that she has a history of numerous prior suicide attempts, at least two involving admissions to an intensive care unit for high lethality. Her recent hospitalization had been precipitated by a suicide attempt following the dissolution of a romantic relationship.

While the patient endorses suicidal ideation, she also indicates that she feels suicidal almost every day and currently feels close to baseline in this regard. She has a plan to manage safety in place, is engaged with a mental health provider with whom she describes a strong therapeutic relationship, and has been taking her medications and maintaining sobriety since discharge from the hospital a few weeks back. The patient acknowledges having made some statements suggesting suicidal feelings when she first arrived at the emergency room, but she now calmly and cogently explains that she was really in a panic at that time and is presently feeling more at ease and stable, much like she had been before her vehicular mishap. She reports that she has generally done well since leaving the hospital, is in a new job that she is really invested in, and has been working to repair some relationships that have suffered as a consequence of some of her behaviors leading up to her last hospital admission.

One-dimensional stratification (involving severity only) often fails to fully reflect the complexity of an individual's suicide risk in the short- and long-term, and sometimes creates scenarios that present clinicians with double-edged swords. In the hypothetical clinical encounter described above, it might reasonably be determined, in light of suicidal ideation at baseline levels and the mental health care and safety plan that are in place, that discharge from the emergency room and follow-up with established mental health providers is both safe and appropriate. What single qualifier best reflects this patient's suicide risk? Some clinicians will opt to call this person low risk for suicide, thereby explaining the decision to release her from the emergency room and not pursue involuntary admission. But, in the event of an unfortunate outcome

involving a subsequent suicide or suicide attempt, such a low risk designation would be hard to justify given the patient's history of prior suicide attempts and her being within a particularly high risk time period involving the first month after discharge following a psychiatric admission precipitated by a suicide attempt. Alternatively, a high risk designation perhaps makes the plan involving discharge from the emergency room seem untenable, and it might be hard to explain such a decision given that risk designation if a bad outcome were to follow. Splitting the difference and designating intermediate suicide risk fails to accurately reflect the formulation regarding risk in the short and long term, nor does it optimally inform clinical decision-making. A single designation ultimately fails to capture the nuanced nature of this patient's suicide risk and portends vulnerability from a medicolegal perspective in the event of a subsequent suicide or suicide attempt.

This dilemma can be circumvented by a two-dimension risk stratification that denotes both severity and temporality. Our hypothetical patient is unavoidably at high risk for suicide on a chronic basis by virtue of her diagnoses and multiple prior suicide attempts. At the same time, her current stability and sobriety, suicidal ideation at baseline levels without any acute intent, and good treatment adherence with a strong therapeutic relationship, all portend low acute risk for suicide. Hospitalization at this juncture is unlikely to have a meaningful impact on chronic risk in a favorable way, and it might even interfere with the protective factors (e.g., employment) that are mitigating risk on a long-term basis. All of this is better reflected in a two-dimensional risk designation reflecting low acute risk for suicide, with associated high chronic risk. From the medicolegal perspective, such a designation reflects the provider's awareness and consideration of risk and protective factors, and the strong potential for future self-directed violent behavior on a long enough timeline. But this designation also supports the decision not to hospitalize, reflecting that the patient's heightened risk is predominantly chronic in nature, so that it is appropriately addressed in the context of long-term outpatient therapy with established providers.

Two-dimensional risk assessment, involving the distinction between acute and chronic risk, is not without precedent.⁴⁻⁶ In the following sections, we

present risk stratification nomenclature and discuss the clinical implications associated with it.

Acute Suicide Risk

High acute risk. The essential features of high acute risk for suicide involve both suicidal ideation with the intent to die by suicide and the inability to maintain safety independent of external support or help. Various warning signs and/or risk factors are likely to be present in such scenarios, such as plans to die by suicide; access to the means needed to execute a suicide plan; recent or ongoing preparatory behaviors and/or suicide attempt; acute psychiatric illness, such as an active major depressive episode, acute psychosis, and/or drug or alcohol relapse; exacerbation of a personality disorder, such as increased behaviors associated with a borderline personality disorder; and acute psychosocial stressors such as job loss, dissolution of a relationship, or incarceration. High acute risk for suicide typically mandates psychiatric hospitalization to maintain safety and aggressively target the modifiable factors driving the acute spike in suicide risk. Individuals at high acute risk for suicide require direct observation until they are on a secure psychiatric unit, and they should be maintained in an environment with limited access to lethal means (e.g., no access to sharps, cords/tubing, or toxic substances).

Intermediate acute risk. The essential feature of intermediate acute risk is the perceived ability to maintain safety independent of external support or help. Needless to say, the determination as to whether or not the patient can independently maintain safety will involve a clinical judgment based on the totality of available clinical data. Patients at intermediate acute risk for suicide may present in a manner that is quite similar to those deemed to be at high acute risk for suicide, and they frequently share many of the same clinical features. The only difference may be a lack of intent, based on an identified reason for living (e.g., children), and the ability to abide by a safety plan and maintain safety independently. Recent preparatory behaviors are likely to be absent in such clinical scenarios. It is, of course, prudent to consider psychiatric hospitalization for these individuals. Hospitalization may address suicidal thoughts and/or behaviors, especially if pertinent modifiable factors driving suicide risk are amenable

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to treatments best accomplished in an inpatient setting (e.g., acute psychosis warranting aggressive medication management/adjustment). Outpatient management should be intensive, with frequent contact, regular reassessment of suicide risk, and a well articulated safety plan.

Low acute risk. Low acute risk typically involves clinical presentations in which current suicidal intent, a suicide plan, and preparatory behaviors are all absent. There should be high collective confidence (e.g., patient, clinician, and family members) in the ability of the patient to independently maintain his or her own safety. It is important to recognize that persons at low acute risk for suicide may still have suicidal ideation, but it will be without associated intent or plan. If a suicide plan is present, the plan is general and/or vague, without any associated preparatory behaviors, and/or is contingent on some potential eventuality (e.g., "I'd shoot myself if things ever got bad enough, but I don't have a gun"). Collective confidence regarding the ability to independently maintain safety will typically be associated with commensurate ability in the individual to engage appropriate coping strategies and the person's willingness and ability to utilize a safety plan in the event of future heightened suicidal intent.

Chronic Suicide Risk

High chronic risk. A variety of risk factors are typically associated with high chronic risk for suicide. Examples include chronic major mental illness and/or personality disorder, history of prior suicide attempt(s), history of substance abuse/dependence, chronic pain, chronic suicidal ideation, chronic medical illness, limited coping skills/abilities, unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment), and limited ability to identify reasons for living. Conceptually, these are individuals who are at chronic risk for becoming acutely suicidal, typically in the context of unpredictable albeit often inevitable situational contingencies (e.g., job loss, relationship turmoil/dissolution, drug or alcohol relapse). Hence, these patients require routine mental health follow-up, a well-articulated safety plan, and routine screening regarding risk for suicide. Means restriction should be part of their management/safety planning (e.g., no access to guns, limit-

ed medication supplies). Development of coping skills and augmentation of protective factors are important components in efforts to mitigate chronic suicide risk.

Intermediate chronic risk. Individuals at intermediate chronic risk for suicide may present with many of the same factors associated with high chronic suicide risk, such as diagnoses of major mental illnesses and/or personality disorders, substance abuse/dependence, and/or chronic medical conditions or pain. However, in these individuals, the relative balance of protective factors, coping skills, reasons for living, and psychosocial stability suggests an enhanced ability to endure future crises without resorting to self-directed violence and/or suicidal behaviors. Such patients will require routine mental health care in efforts to optimize their psychiatric condition and maintain or enhance their coping skills and protective factors. A safety plan should be in place.

Low chronic risk. This designation will capture a broad range of individuals, from persons with little or no mental health or substance abuse problems to individuals dealing with significant mental illness but with a relative abundance of coping strengths and resources. Individuals with low chronic risk for suicide have a history of managing stressors without resorting to suicidal ideation. The following factors will typically be absent: history of self-directed violence, chronic suicidal ideation, tendency toward highly impulsive, risky behaviors, severe, persistent mental illness, and marginal psychosocial functioning.

Summary

In our experience, the two-dimensional risk stratification system described here offers many advantages over designations that only qualify severity of risk and lack any temporal referent. By offering two separate designations for risk severity, one for acute risk and another for chronic risk, a patient's risk for suicide can be conceptualized and communicated at a far more nuanced level. This level of detail is most relevant for high risk individuals, in whom acute and chronic risk can be, and often are, dissociable. As illustrated in our hypothetical case example, an individual may simultaneously be at low acute risk for suicide despite high chronic risk. Many individu-

als struggling with chronic suicidal ideation will frequently present with this combination of low acute and high chronic risk. Accurate formulations reflecting degree of suicide risk in both the short and long term are needed to facilitate good clinical decision-making. Without this ability, it will be difficult to determine if and when hospitalization is warranted, and how to optimally balance the principles of autonomy, non-maleficence, and beneficence in this challenging clinical population. Stratifying risk in terms of both severity and temporality not only helps clinicians identify situations in which involuntary hospitalization is warranted, but it also helps avoid unnecessary admissions that may be harmful to therapeutic relationships and protective factors that ultimately serve to mitigate long-term suicide risk. Hence, two-dimensional risk stratification is an essential component of the therapeutic risk management of the suicidal patient. In the next column, we will discuss safety planning, the third essential component of our model.

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