

## Authors' reply

We thank Mathew Large and colleagues for their interest in our article[1]. However, we are concerned that they may have misconstrued the main thrust of our viewpoint. In the article, the inclusion of factors within both the text and the diagram was not because they are clear markers of suicide risk, but because these factors may contribute to distress and can lead to a suicidal crisis, as well as causing more general psychological suffering. Given that the majority of mental health patients present with psychological distress, and some with suicidal thoughts, targeting likely changeable factors therapeutically may help reduce patients' distress and potentially their risk. This approach has the advantage of likely benefiting all. The diagram was included to remind clinicians of the dynamic nature of factors that may contribute to patients' distress and possible risk. The main focus of therapeutic risk management is on reducing distress, including by identifying collaboratively with the patient factors that, if changed, may produce some relief (ideally rapidly). In so doing the clinician and patient work together to identify those factors that require more sustained therapeutic intervention. These positive outcomes (reduction in distress, plans to tackle modifiable factors) arise from establishing a therapeutic alliance, helping a patient feel understood and destigmatised, and instilling hope that their sense of entrapment can be shifted. There is increasing evidence of the benefits of the therapeutic alliance in reducing suicidal thoughts and behaviour[2]. The process and recording of a safety plan is another positive outcome from this alliance, reinforcing any short-term reduction in distress by providing the patient with the tools to manage their next episode of crisis and, potentially, thoughts of suicide.

We also thank Stephanie Penney and Alexander Simpson for their comments. We agree that there are major parallels between issues regarding risk assessment of violence and suicide. It is interesting that some violence risk prediction tools appear to perform somewhat better than equivalent measures for suicide prediction[3], although their predictive ability in individual patients is extremely limited. Penney and Simpson rightly emphasise how societal expectations that we can predict risk of both suicide and violence places a heavy and unrealistic burden on clinicians. This may deflect attention away from therapeutic risk management, whereby interventions can lower risk through enhancing for patients' wellbeing.

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## References

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