Correspondence

The Health of the Nation and suicide prevention

Sir: *The Health of the Nation* (Department of Health, 1992) envisages a significant reduction in suicide rates by the year 2000. However, official suicide rates may not be a valid indicator of a nation's mental health. First, there are a multiplicity of variables that influence suicide rates, of which psychiatric factors are only one. Second, official suicide rates underestimate the true numbers of people who kill themselves. Furthermore, we would argue that the targets set fail to take account of the complexity of suicide prevention.

Is has been suggested that one way of achieving *Health of the Nation* targets is identification of people who are considered to be 'at-risk' for suicide. There are, however, general principles in relation to screening that need to be considered. Screening has resource implications which can only be warranted if manifest benefit can be demonstrated. A prerequisite of effective screening instruments is that they should demonstrate acceptable specificity and sensitivity. As yet, however, no such instrument exists. In one study, for example, (Nordentoft *et al*, 1993) risk factors for suicide taken in combination had a sensitivity of 60% and a specificity of 61%. It follows that screening for at-risk cases would currently result in unacceptable numbers of both 'false positives' and 'false negatives'. In addition, for screening programmes to be worthwhile there should be good evidence that intervention subsequent to the identification of the target population is effective. However, subgroups of people who are identified in studies as being at-risk for suicide typically include people with personality disorders, substance abusers, the socially isolated and the unemployed. The effectiveness or appropriateness of psychiatric intervention among these sub-groups is, at best, uncertain.

It is a straightforward task to ascertain official suicide rates and set targets for their reduction. There are strategies that may help to reduce suicide numbers, such as improved detection and management of depressive illnesses (Rutz *et al*, 1989) and the use of antidepressant drugs that are less toxic in overdose. We believe, however, that there should be more debate with regard to the feasibility of achieving the *Health of the Nation* goals. If, by the year 2000 these targets have not been realised, this may not be due to failure on the part of clinicians, but rather that the goals set were unrealistic in the first place.

DEPARTMENT OF HEALTH (1992) *The Health of the Nation: strategy for health in England*. London: HMSO. (Cmnd 1986).

NORDENTOFT, M., BREUM, L., MUNCK, L.K., NORDESTGAARD, A.G., *et al* (1993) High mortality by natural and unnatural causes: a 10 year follow up study of patients admitted to a poisoning centre after suicide attempts. *British Medical Journal*, **306**, 1637–1641.

RUTZ, W., VON KNORRING, L. & WALINDER, J. (1989) Frequency of suicide on Gotland after systematic postgraduate education of general practitioners. *Acta Psychiatrica Scandinavica*, **80**, 151–154.

ELISABETH A. ASHBRIDGE and STEVEN MILNE, *St Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne NE3 3XT*

Prevention in psychiatry

Sir: The authors of the Report of the Special Committee on the Place of Prevention in Psychiatry (CR21, Royal College of Psychiatrists, 1993) deserve to be commended for their balanced and thoughtful approach. In particular their conclusion that "evidence is not yet available to justify a large diversion of treatment resources to prevention . . ." (Paykel, 1993) should be remembered by all those involved in the management and planning of patient care.

It is vital that psychiatrists resist the overly prescriptive view that there are certain ideal lifestyles and forms of social existence which are 'better' at preserving mental health than others. Not only does this invite a return to more paternalistic practice but, as the report shows, is often tendentious. We must continue to allow patients to follow their own lifestyles and base our advice and intervention only on scientifically proven preventive measures. To interfere in patients' everyday existence is a responsibility which should never be taken lightly, especially on the basis of unresearched speculative theories.

PAYKEL, E.S. (1993) Prevention in psychiatry, *Psychiatric Bulletin*, **17**, 633.

JOHN COATES, *Belfast City Hospital, Belfast BT9 7AB*

Working in a child guidance clinic

Sir: I was interested to read the letter by Jan Hermsen on 'Working In A Child Guidance Clinic' (*Psychiatric Bulletin*, 1993, **17**, 626). I did my six

months as a senior house officer and the experiences described mirrored mine exactly.

The most enjoyable aspects were being able to work without the interruption of a bleep, enabling one to concentrate wholeheartedly, and becoming part of a new team whose approach was so different from any in a hospital setting. What struck me was that although each person worked autonomously he or she also contributed significantly to the whole team, either in the weekly referral meeting or during daily work.

My experiences have made me more aware of patients' family and social circumstances which can easily be forgotten in a busy acute unit and I would strongly recommend that all trainees spend at least six months working in a child guidance clinic.

HELEN TUCKER, *Torbay Psychiatric Rotation Scheme, Edith Morgan Unit, Torbay Hospital, Torquay TQ2 7AA*

Sir: I was interested to read Jan Hermsen's description of work in a child guidance clinic. (*Psychiatric Bulletin*, 1993, **17**, 626). I am currently working as a registrar in a child and adolescent unit and would agree that an experience in this area is essential for all trainees. The shift to a totally different patient population with their own peculiar set of disorders requires a major rethink of approach, method and technique which can be revealing and, at times, painful.

In this area of psychiatry it is acknowledged that the patient comes as part of a package, i.e. the family. You cannot treat the one without the other. In the clinic in which I work family therapy is a major part of the treatment offered. It has opened my eyes to the importance of an approach neglected or ignored in other areas of psychiatry.

Child and adolescent psychiatry involves the treatment of largely unwilling and involuntary patients who are frequently unable to articulate their problems. The predominantly psychotherapeutic basis of this treatment can be unappealing or alarming to the practitioner. However, trainees can gain vital skills which may not be possible in other specialities.

S. C. CARVILL, *14 Woodloes Road, Shirley, Solihull, West Midlands B90 2RP*

Psychiatric emergencies

Sir: I read with interest Kohen's paper on psychiatric emergencies in people with a mental handicap (*Psychiatric Bulletin*, 1993, **17**, 587–589). We have just completed a survey of all psychiatric emergencies in the Borders region over one year (June 1992 to May 1993). In contrast to Kohen's survey of emergencies seen by a consultant during the daytime in an urban area, most of our cases were seen out of hours by junior doctors and came from a dispersed rural population of 104,000.

During the year there were 13 emergencies with a diagnosis of learning difficulty. This was 2.7% of all psychiatric emergencies. The mean age was 36 with a range of 20–69 years. Eleven were male. Only one of the 13 was seen by a consultant, the others being seen by junior doctors, usually with a co-therapist. Eleven were seen out of hours and all were seen within four hours of referral. The commonest source of referral was from the GP (six cases), and the commonest site of assessment was at home (six cases). Referral was precipitated by self-harm in only one case. Most of the patients had never been married (ten cases), but only one still lived with his parents. The others lived alone (six cases) or with other people (six cases). Just over half were employed full or part-time (seven cases).

Nine patients had another diagnosis apart from learning difficulties. There were five cases of neurotic and stress-related disorders, three of affective psychosis and one of personality disorder. Unlike Kohen's study, none were referred for epilepsy. All the referrals had a history of previous admissions and ten were active cases. The consultant was contacted in only two cases, both times to discuss the decision to admit. Six patients were admitted, the reasons given including risk to self, risk to others, social factors, for assessment and for treatment. Eleven cases were thought to be appropriate emergency referrals.

Only two cases were referred on Saturday and there was no evidence of a 'Saturday afternoon syndrome' as described by Spenser (*Psychiatric Bulletin*, 1993, **17**, 565). This may reflect better local support from the social work department or other differences in local practice. We would not dispute her conclusion that it is important to have provision of emergency short-term beds for assessment and treatment of people with learning difficulties. We had only 13 in-patient beds at the time of this study and would also support Kohen's conclusion that anxiety about emergencies should not deter the implementation of community care. Most of the referrals were appropriate and the actual demand was small and, to a large extent, met by existing out-of-hours arrangements.

JOHN TAYLOR, *Dingleton Hospital, Melrose, Roxburghshire TD6 9HN*

Defeat Depression Campaign

Sir: The thesis of the Defeat Depression Campaign is that patients are reluctant to take

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