Correspondence

Suicide prevention

Sir: Kapur & House (*Psychiatric Bulletin*, September 1998, **22**, 534–536) try an old trick, adjusting my views on suicide prevention to make them an easier target. They also illustrate their arguments with reference to deliberate self-harm, while my paper (Appleby, 1997) was mainly about mental health services where the issues are similar but not the same.

Kapur & House run through the, not entirely unfamiliar, story about the distribution of blood pressure in the population to show the value of preventive strategies which are population-based. But the problem with population strategies is that they do not tell you what to do when it is 4 am and you have two suicidal patients and one bed. For that you need clinical skills. They also imply, in the phrase "with intervention restricted to the high-risk group", that targeting people at high risk would mean discarding the rest – those whose individual risk may be lower but who together contribute most of the suicides. This probably does happen in some self-harm services but in mental health, service input tends to be proportionate to need, including perceived risk of suicide – we may not admit our low-risk patients but we do treat them. However, there is a problem that most of the risk factors on which we base our assessments are common in people with mental illness, and the main purpose of my paper was to consider alternative ways of understanding risk.

Suicide prevention requires a broadly based strategy, one that recognises, as my paper explains in its second paragraph, the influence of social phenomena and at the same time aims to strengthen clinical services. Most commentators on suicide take a similar view and, if I have understood correctly, this is also what Kapur & House mean by a "combined approach". They even believe they thought of it first.

APPLEBY, L. (1997) Assessment of suicide risk. *Psychiatric Bulletin*, **21**, 193–194.

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Sir: Kapur & House (*Psychiatric Bulletin*, September 1998, **22**, 534–536) are of course correct in emphasising that suicide prevention overall is dependent upon many factors, over and above those encompassed by face-to-face clinical skills. In my paper (Morgan, 1997), to which they refer, I made it clear that I agree with this and I too emphasised the gross limitations of statistically derived risk factors which aim to predict suicide, particularly when it occurs in the short term. I certainly do not propound exclusively a "high-risk strategy" for suicide prevention as they imply.

Nevertheless, I am glad to have the opportunity to clarify what I meant by my assertion that provided we pay sufficient attention to our clinical skills, suicide rates will "look after themselves". My purpose here was to remind clinicians of the paramount importance of clinical skills in both assessing and managing suicide risk. Certainly wider issues such as reducing the availability of method or improving socio-economic conditions are important in their own right. But in our day-to-day work as clinicians we regularly come into face-to-face contact with high-risk individuals, and I believe we have a duty to ensure that the clinical skills such as those I identified in my paper are kept at a high order. Yet where in the literature are these considered systematically, and how do they fit into the present day focus on evidence-based medicine? I fear that in general the evaluation and development of such skills take place far from regularly and at no more than a perfunctory level, although I would be happy to be proved wrong. By all means let us try to alleviate the whole spectrum of possible causes of suicide, but before we distribute our energies widely in such a way should we not ensure first that we have put our own house in order?

MORGAN, G. (1997) Management of suicide risk. *Psychiatric Bulletin*, **21**, 214–216.

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Stigma campaigns

Sir: Is a campaign against stigma the losing response of any medical speciality? Is it a good idea to introduce the idea of 'stigma' to those who may agree, but more importantly to those who may not have thought that way until nudged?

Doctors in venereology did not seek to engage us directly about the unpleasantness which can lurk in the moist tufted areas or cavities of our

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