BJPsych | The British Journal of Psychiatry (2012) 201, 410–412

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

- High-risk strategies *v.* universal precautions against suicide
- Child conduct problems and social skills in a middle-income country
- Assessing the role of cerebrovascular disease in the incidence of geriatric depression

High-risk strategies *v.* universal precautions against suicide

The recent paper by Gunnell *et al*[1] and the accompanying editorial by Pitman & Caine[2] clearly outline the practice and principles of a contemporary approach to suicide prevention in mental health settings. However, I do not think the policy initiative that every patient with a serious mental illness or a recent episode of self-harm should be followed up within a week of discharge is really a high-risk approach to suicide prevention. Patients who self-harm and those with serious mental illness must constitute the vast majority of people who are admitted to psychiatric hospitals and therefore this recommendation is more like a universal precaution against suicide than a targeted intervention based on a high-risk model.

In my view there are compelling reasons to doubt the usefulness of high-risk categorisation for future suicide at the point of discharge from psychiatric hospitals. It is known that discharged patients have about a 100-fold increased risk of suicide compared with the general community in their first few weeks at home.[3] However, those categorised as at high risk of suicide after discharge are only about four times more likely to take their own life than discharged patients categorised as at low risk of suicide.[4] Hence, compared with the risk of just being a discharged patient, being at high risk or low risk is virtually meaningless.

If the English guideline for early follow-up of patients has been successful, this is almost certainly because it approximates a universal precaution against suicide and not because of the success of a high-risk approach. We need to acknowledge that all those admitted to psychiatric hospitals have a very high absolute risk of suicide and that we are unable to tell who will be safe.

1 Gunnell D, Metcalfe C, While D, Hawton K, Ho D, Appleby L, et al. Impact of national policy initiatives on fatal and non-fatal self-harm after psychiatric hospital discharge: time series analysis. *Br J Psychiatry* 2012; **201**: 233–8.

2 Pitman A, Caine E. The role of the high-risk approach in suicide prevention. *Br J Psychiatry* 2012; **201**: 175–7.

3 Qin P, Nordentoft M. Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers. *Arch Gen Psychiatry* 2005; **62**: 427–32.

4 Large M, Sharma S, Cannon E, Ryan C, Nielssen O. Risk factors for suicide within a year of discharge from psychiatric hospital: a systematic meta-analysis. *Austr N Z J Psychiatry* 2011; **45**: 619–28.

Matthew M. Large, Psychiatrist, University of New South Wales, Sydney, Australia. Email: mmbl@bigpond.com

doi: 10.1192/bjp.201.5.410

Authors' reply: Large highlights two issues in relation to suicide prevention: (a) the differing terminology used internationally in relation to models of suicide prevention; and (b) the difficulties inherent in assessing suicide risk following discharge from psychiatric hospital.

Whereas in the UK the terms high-risk (or targeted) approach and population (or mass) approach are used commonly,[1] terminology in the USA and elsewhere differs, referring to universal, selective and indicated interventions.[2] A universal intervention corresponds to the population approach, in that it is applied to a broad population irrespective of the risk of individual members, in order to change norms and values, to influence unidentified members of the population who may carry more risk and, ultimately, to shift the risk of the entire population. At the other end of the spectrum, an indicated intervention corresponds to a high-risk approach, in that it is applied to identified symptomatic individuals. It is much the same as a clinical intervention except that public health approaches proactively reach into communities and diverse settings to engage such persons, whether or not they present in clinical settings.

Selective interventions equate to a form of high-risk approach, but one which addresses groups with a significantly higher-than-average risk of developing mental disorders or adverse outcomes.[2] Such groups are described in the 2012 suicide prevention strategy for England as those 'with particular vulnerabilities or problems with access to services' (p. 21).[3] The groups listed include children and young people; people with a history of childhood abuse; minority ethnic groups and asylum seekers; and people with untreated depression. These are distinguished from groups regarded as high risk for completed suicide on the basis of clear epidemiological evidence, which in the English strategy include people under the care of mental health services; people with a history of self-harm; people in contact with the criminal justice system; adult men under 50; and specific occupational groups. Whereas effectiveness studies tend to concentrate on proximal interventions for these highest-risk groups, less evidence describes the effectiveness of selective interventions, but this situation is likely to evolve.

In relation to the second issue that Large raises, also highlighted in his recent letter to *The Psychiatrist*,[4] it would be fair to say that anyone admitted to hospital for a major mental disorder, or a substance use disorder, has a greater degree of risk for suicide than non-hospitalised individuals with mental disorders or the general population. However, people in contact with mental health services in the year prior to death account for 27% of general population suicides in England.[5] Gunnell *et al*'s study[6] found that 10% of all suicides in England occurred within the year following psychiatric discharge. Applying the term 'high risk' to this group of patients describes their overall risk in relation to the general population, ignoring the wide degree of variation in risk between individuals within this group. One could argue that integrated aftercare constitutes high-quality care for all but, on the basis of the above taxonomies, we would not regard this as universal because it is indicated for all such discharged patients.

1 Rose G. Sick individuals and sick populations. *Int J Epidemiol* 1985; **14**: 32–8.

2 Knox K, Conwell Y, Caine E. If suicide is a public health problem, what are we doing to prevent it? *Am J Public Health* 2004; **94**: 37–45.

3 Department of Health. *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives*. HM Government, 2012.

4 Large M, Ryan CJ, Callaghan S. Hindsight bias and the overestimation of suicide risk in expert testimony. *Psychiatrist* 2012; **36**: 236–7.

5 Appleby L, Kapur N, Shaw J, Hunt IM, Flynn S, While D, et al. *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Wales, Scotland and Northern Ireland*. The University of Manchester, 2012.

https://doi.org/10.1192/bjp.201.5.410 Published online by Cambridge University Press