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Letter to the Editor

Transfer of suicide risk *versus* looking at suicides outside hospital in general

Kapur *et al*.'s (2012) research showed that in-patient suicide in England has decreased considerably, especially death through hanging. They also mentioned that they could not exclude that some of the risk might have been transferred to other services such as home treatment teams, because the absolute number of suicides in patients under the care of a home treatment team has risen. Previously published research from the same group showed that there are fewer suicides of in-patients in areas where home treatment team policies had been implemented, but the reduction of suicides in the community was not statistically significant in the same areas (While *et al*. 2012). The question is what the potential consequences of these findings are for clinical practice and service organization. The level of which team looks after which type of patient does not seem the most informative.

From a clinical and public health perspective there are, broadly speaking, two types of measures one can take to prevent suicide: preventing access to means and assessing the suicide risk clinically and trying to reduce it. Suicide is a rare event and therefore very difficult to predict, even when there are scales available which show significant differences between people with high and low risk (Szmukler *et al*. 2012). Preventing access to means seems a more promising approach both at ward level, for example removing ligature points, and in the community, for example limiting the amount of paracetamol people can buy in one purchase (Hawton, 2007). The measures one can take in home treatment teams or community mental health teams are limited, although one can take medication away and the patients will benefit from the general community measures.

The authors do make a difference between suicide through hanging on the ward and outside the ward (i.e. patient on leave), but they do not report this for other methods. However, besides studying whether risk is transferred to different teams, it would be interesting to see whether there is a trend in suicide of all mental health patients who are physically outside the hospital. An increase would be worrying, even if there is decrease in the total number of suicides, because it would imply that clinical risk prediction had become less good or that health professionals had been unable to act on the high risk, for example due to lack of admission facilities.

Declaration of Interest

None.

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Transfer of suicide risk *versus* looking at suicides outside hospital in general – a Reply

We thank Dr Hubbeling for her interest in our article (Kapur *et al*. 2012). She questions the relevance of treatment setting in suicide risk and prevention. We would disagree that the investigation of treatment setting is uninformative. The aetiology of suicide is complex and requires multifaceted prevention programmes. Treatment setting is crucial in that it helps services to focus on specific preventative efforts. Indeed, as Hubbeling herself notes, preventative actions vary according to where care is being provided. For example, preventing access to ligature points is