
Correspondence

Assessment of suicide risk

Sir: Appleby (*Psychiatric Bulletin*, April 1997, **21**, 193–194) recognises the absence of convincing evidence for the effectiveness of clinical services in reducing suicide. He goes on to support the need to promote risk assessment. The case for this emphasis on risk assessment is often based on the finding that a significant proportion of patients who commit suicide communicate in some way the possibility that this may occur. However, I believe the much larger group of patients, who communicate such ideas for whom suicide is not the outcome, may suffer as a result of the unquestioning acceptance of some features of conventional methods of assessing risk.

Thoughts of self-harm or suicide do not exist in isolation. By focusing our questions on these cognitions we fail to acknowledge the complex and varied aetiology of such thoughts and to a certain degree ignore other cognitive manifestations of emotions. In addition we develop a specific vocabulary in which emotional distress is replaced by terms purported to reflect risk. Patients recognise our disproportionate interest in this aspect of their 'complaints' and in an attempt to convey their distress soon 'learn' this vocabulary. This then obscures the nature of the actual distress which has obvious implications for any interventions. In the extreme a patient may be criticised for using this language which they have been coerced into so doing.

Laing (1960) argues that psychiatrists apply a diagnosis merely on the basis of a breakdown of communication between the psychiatrist and the patient. On the other hand, however, where communication is enhanced due to the development of a common language (on the doctor's terms), the psychiatrist teleologically also identifies morbidity. While no significant impact has been made on the rate of suicide, despite repeated fine-tuning to the risk assessment procedure, I feel we should question the effects (both the absence of a positive effect and the possible presence of a negative effect) of this aspect of the current approach. Similarly, we should be alert to the consequences of the development of such forms of communication within all therapeutic relationships.

LAING, R. D. (1960) *The Divided Self: A Study of Sanity and Madness*. London: Tavistock.

RAJAN NATHAN, *Psychiatric Registrar, Roundhay Wing, St James's University Hospital, Beckett Street, Leeds LS9 7TF*

Sir: As Director of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Louis Appleby begins his editorial (*Psychiatric Bulletin*, April 1997, **21**, 193–194) by correctly asserting that the main causes of suicide are social and that there is no evidence that psychiatrists can do anything to exert a meaningful influence upon suicide rates. However, he appears to retain the assumption that doctors could still do better if they tried harder. In describing a study by his own group (Dennehy *et al*, 1996), he notes that half of the patients who went on to suicide did not express suicidal ideas to medical attendants "suggesting that some people indicate their risk in less direct ways". It is possible that many people will not indicate the risk in any way and that doctors, being neither omniscient nor omnipotent, are very frequently incapable of doing anything at all.

Despite the lack of any evidence to support the view, I believe that what psychiatrists can do to prevent suicide is little better than rearranging the deckchairs on the *Titanic*. At least while the country is steered on a course, from which the profession has little power to deflect it, towards the icebergs of growing social inequalities, youth unemployment and underfunded health and community care, perhaps the best we can hope for is to help some of our suicidal patients to clamber into the lifeboats. Given the present evidence, we delude ourselves and we risk a dangerous and counterproductive collusion with the captains of the ship, if we suggest that we can do more.

DENNEHY, J. A., APPLEBY, L., THOMAS, C. S., *et al* (1996) Case-control study of suicide by discharged psychiatric patients. *British Medical Journal*. **312**, 1580.

JOHN M. EAGLES, *Consultant Psychiatrist, Grampian Healthcare NHS Trust, Clerkseat Building, Cornhill Hospital, Aberdeen AB9 2ZH*

Description of primary delusions: confusion in standard texts and among clinicians

Sir: McAllister-Williams highlights the confusion that exists in the definition of the term "primary delusion" (*Psychiatric Bulletin*, June 1997, **21**, 346–349). The second version of the Schedules for the Clinical Assessment in

Neuropsychiatry (SCAN; World Health Organization, 1994) offers another view on this and related terms.

SCAN refers to "delusional perception or primary delusion", suggesting that these terms are synonymous. If this interpretation is correct it implies that delusional mood, delusional memory (as defined by some) and the autochthonous delusion are not different forms of primary delusion, but are altogether different entities according to SCAN.

SCAN defines delusional perception as "an intrusive, often sudden knowledge that a common perception has a radically transformed meaning . . ." but goes on to add ". . . a normal perception, image or memory takes on an entirely new significance." Thus this definition includes what some would term a delusional memory.

Delusional memory 'proper' is recognised and rated as a separate item in SCAN and is defined as "experiences of past events which clearly did not occur." This is consistent with Sims' view (1988) of a delusion retrojected in time, although not so with Gelder *et al's* view (1989) that delusional memories are delusional interpretations of real memories.

Similarly delusional mood is not a form of primary delusion according to SCAN. Being both rare and difficult to distinguish from other psychotic and non-psychotic symptoms, delusional mood is only rated as present when other delusions are subsequently formed. Furthermore, no mention is made at all of the autochthonous delusion in SCAN.

SCAN is now an established research instrument which aims to improve interrater reliability in the recognition and assessment of a variety of psychiatric phenomena. This is achieved through the use of strict differential definitions of psychopathological symptoms and signs, as described in the SCAN glossary. While these do not fully concur with other authorities, adopting these definitions in clinical practice does at least provide the opportunity to improve reliability between clinicians and reduce the confusion which currently exists.

GELDER, M., GATH, D. & MAYOU, R. (1989) *Oxford Textbook of Psychiatry* (2nd edn). Oxford: Oxford University Press.

SIMS, A. (1988) *Symptoms in the Mind. An Introduction to Descriptive Psychopathology*. London: Baillière-Tindall.

WORLD HEALTH ORGANIZATION (1994) *Glossary: Schedules for Clinical Assessment in Neuropsychiatry* (version 2.0). Geneva: American Psychiatric Press.

IMAD M. ALI, Senior Registrar, Gwent Community Health NHS Trust, Tahlgarn, County Hospital, Griffithstown, Pontypool, Gwent NP4 5YA

Phlebotomists – not always a good thing

Sir: Like many others we have introduced phlebotomists onto our admission ward, as taking blood is now seen as a non-educational activity for junior doctors. However, our juniors themselves have noticed some unexpected drawbacks. If blood is taken at the end of the initial consultation, a patient may often speak a little more freely, believing that the formal interview is over, thereby revealing further important features of his/her mental state. Taking blood for liver function tests serves as a useful *aide-mémoire* to enquire about an alcohol history. All too often, the less demanding in-patients can easily be forgotten by the doctors. A blood sample can be a useful way to at least keep an eye on one or two. Finally, incoming general practice registrars can feel uncertain and lost at the start of a six-month psychiatry attachment. The task of taking blood can be a familiar landmark in an otherwise confusing experience, and can be the start of adjustment to and integration within the team.

G. E. P. VINCENTI, *Consultant Psychiatrist, Northallerton Health Services NHS Trust, Department of Mental Health, Friarage Hospital, Northallerton, North Yorkshire DL6 1JG*

Responsible medical officers and keyworkers: a conflict of roles

Sir: I have been involved in the teaching of a course for keyworkers for some time. A particular question has arisen with practically every one of these groups, namely: How do we resolve whether the responsible medical officer or the keyworker coordinates the care plan for each patient, given that both are given the same role under the Care Programme Approach?

This is a reasonable question. Paragraph 15.5 of the *Code of Practice* (Department of Health & the Welsh Office, 1993) states that "treatment plans are essential for both informal and detained patients. Consultants should coordinate the formulation of a treatment plan in consultation with their professional colleagues. The plan should be recorded in the patient's clinical notes". At the same time, Paragraph 3.2.18 of *Building Bridges – a Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People* (Department of Health, 1995) states: "As well as coordinating the Care Plan, keyworkers/care managers may also provide an element of the plan in their own right".

Insofar as Treatment Plans and Care Plans are one and the same, it is true that government