part of the table or of ≥20 in total indicates that the person is in imminent danger and should not be left alone; 14-19 (high risk) indicates that another meeting should be fixed soon; 6-11 (moderate risk) indicates that another meeting should be fixed; and 1-5 (slight risk) or 0 in the first part of the table (no suicidal intent) indicates that the volunteer should hear the person out and let him or her go unless there are other reasons to meet again.

Scoring table used to assess risk of suicide

Choose one figure to score suicide plan	
Chief indicator of immediate risk:	
Imminent sudden death	8
Imminent slow method of suicide	7
Future sudden death planned	6
Future slow method of suicide planned	5
Planning suicide "gamble"	4
Planning suicidal gesture	3
Definite suicidal thoughts but no plan	2
Toying vaguely with idea of suicide	1
No suicidal thoughts	0
Add points for every relevant item, mostly the long term factors	
Previous suicidal acts or gestures	≤4
Recent broken relationship	3
Isolation. Rejection	3 (each)
No hope. Loss of faith	3 (each)
Depressive illness	3
Dependence on alcohol or drugs	2
Possession of means of suicide	2
Putting affairs in order	2
Over 60. Male. Ill. Chronic pain	1 (each)

The volunteers then apply the table to clinical examples (described or used in role play), assess the risk, and select the appropriate response. The method is crude, and precision is not claimed; for example, some workers might rate depressive illness higher than items such as isolation or rejection. When applied to the clinical examples, however, the scoring table produces results that look fairly convincing, and as a training tool it works well.

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Deal with self harm in prisons

EDITOR,—There seems to be sense in what both Greg Wilkinson and H G Morgan say about the prevention of suicide.[1] Setting targets for reducing suicide is a facile and superficial way of attempting to measure the efficacy of mental health services, ignoring as it does the huge sociocultural influences over this behaviour. In an age of mass unemployment and social disintegration the concept of "anomie" as described by Durkheim a century ago is surely relevant.[2]

On the other hand, we should not ignore the situations in which it may be possible to prevent suicide. A recent study has shown that suicide rates in young men aged 15 to 19 have risen in recent years.[3] While the authors suggest that factors such as unemployment and poverty may contribute to this, some of these deaths occur in custodial settings. Suicide rates in prison are several times those in the general population. Judge Tumim has drawn attention to this and identified factors in the prison environment that could heighten the risk for vulnerable prisoners.[4] Unsympathetic regimes with poor training of staff and low morale can have a deleterious effect, and their responses to self harm can be counterproductive and harmful. Morgan is surely right in emphasising the importance of establishing a therapeutic alliance with those at risk of self harm and suicide, but the absence of this is apparent in many custodial settings. A disproportionate number of acts of self harm in prisons occur among young prisoners. Liebling suggested that self harm in prisoners often occurs in a "poor coping" group, who find adjustment to prison life difficult.[5] Factors such as bullying may be particularly important in young prisoners.

To deal with self harm in prisons the approach must move beyond the identification of those at risk. Addressing the factors in the prison environment that precipitate suicide attempts and the attitudes of staff and prisoners to this problem could be highly beneficial. Allied with an increased emphasis on "certain basic clinical skills: a sympathetic ear . . . a quiet confidence," this might lead to safer custodial care of a highly vulnerable group of young people. This is an important and pressing social issue worthy of further study.

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1 Wilkinson G, Morgan HG. Can suicide be prevented? *BMJ* 1994;309:860-2. (1 October.)
2 Durkheim E. *Suicide.* London: Routledge and Kegan Paul, 1970. (First published 1897.)
3 McClure GMG. Suicide in children and adolescents in England and Wales 1960-1990. *Br J Psychiatry* 1994;165:510-4.
4 Home Office. *Report of a review by her majesty's chief inspector of prisons for England and Wales of suicide and self-harm in prison establishments in England and Wales.* London: HMSO, 1990.
5 Liebling A. *Suicides in prison.* London: Routledge, 1992.

Antidepressants and suicide

EDITOR,—Erkki Isometsä and colleagues[1] supported the main conclusion of our toxicological study of suicides over two years in Sweden[2]—namely, that underprescribing and therapeutic failure are greater problems than toxicity with antidepressants. Isometsä and colleagues studied 1397 suicides in Finland during 1987-8; 57% of the victims were depressed. Antidepressants were prescribed to only a third of those with major depression (3% at adequate doses). Altogether 1348 subjects were investigated toxicologically in the same Finnish study, and Erkki Vuori and colleagues confirm our toxicological finding that less than 16% of the patients who committed suicide were taking antidepressants at the time of death.[3] They report that antidepressants were detected in 38 of the 1083 people who committed suicide by means other than self poisoning. If all the remaining 265 people were taking antidepressants, a maximum proportion of 22% ((38+265)/1348) is reached. As, however, only a third of the subjects with major depression had been prescribed antidepressants, it is likely that less than a third of the 265 who died of self poisoning were positive for antidepressants, which suggests that at most 9% of the Finnish patients who committed suicide were being treated with antidepressants at the time of death.

Vuori and colleagues have doubts about the validity of our "post-mortem study on antidepressant effect." A weaker antidepressant effect is one possible explanation of our finding that moclobemide and mianserin had a higher association with suicide than did other antidepressants. In the case of moclobemide this is supported by results from prospective clinical trials.[4] We have discussed alternative explanations in a previous reply to correspondence[5] and in a paper.[6] The purpose of studies like ours, however, is to provide early signals on risks with new drugs (for example, rare interactions, sudden deaths, suicides, and therapeutic failures, which are seldom found in premarketing trials or reported in spontaneous adverse reporting systems).[7-9] A meta-analysis of the clinical trials of fluoxetine[10] was of too low statistical power to be able to detect a possible 50% increased risk of suicide.[11] That would have required 42 000 subjects. Alternative approaches have therefore been proposed for postregistration surveillance.[7,11] Results from non-experimental studies must, however, be interpreted cautiously and validated by further studies[2]. Also, experimental studies, which are often unable to show differences in effect, must be interpreted critically with regard to their low power (type II error).[2,4,11]

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1 Isometsä E, Henriksson M, Heikkinen M, Aro H, Lönnqvist J. Suicide and the use of antidepressants. *BMJ* 1994;308:915. (2 April.)
2 Isacsson G, Holmgren P, Wasserman D, Bergman U. Use of antidepressants among people committing suicide in Sweden. *BMJ* 1994;308:506-9. (19 February.)
3 Vuori E, Lönnqvist J, Klaukka T. Antidepressants and suicide. *BMJ* 1994;308:1573. (11 June.)
4 Gram LF, Isacsson G, Bergman U. Moclobemide. *Lancet* 1994;343:679-80.
5 Isacsson G, Holmgren P, Wasserman D, Bergman U. Suicide and the use of antidepressants. *BMJ* 1994;308:916. (2 April.)
6 Isacsson G, Redfors I, Wasserman D, Bergman U. Choice of antidepressants: questionnaire survey of psychiatrists and general practitioners in two areas of Sweden. *BMJ* 1994;309:1546-9. (10 December.)
7 Bergman U. Pharmacoepidemiological perspectives. *J Clin Epidemiol* 1992;45(3):313-7.
8 Henry JA. The safety of antidepressants. *Br J Psychiatry* 1992;160:439-41.
9 Mehtonen O-P, Aranko K, Mälkonen L, Vapaatalo H. A survey of sudden death associated with the use of antipsychotic or antidepressant drugs: 49 cases in Finland. *Acta Psychiatr Scand* 1991;84:58-64.
10 Beasley CM Jr, Dronseif BE, Bosomworth JC, Sayler ME, Rampey AH Jr, Heiligenstein JH, *et al.* Fluoxetine and suicide: a meta-analysis of controlled trials of treatment for depression. *BMJ* 1991;303:685-92.
11 Li-Wan-Po A. Fluoxetine and suicide: meta-analysis and Monte-Carlo simulations. *Pharmacoepidemiology and Drug Safety* 1993;2:79-84.

Patient confidentiality in New Zealand

EDITOR,—Charles Essex's news article concerning the confidentiality of patients' medical files in New Zealand is a one sided representation of the facts.[1] The Northern Region Health Authority in New Zealand is responsible for paying various subsidies to medical practitioners in its region. Health Benefits Limited is the agent of the regional health authority that makes these payments and also investigates any apparent inappropriate claims. The statutory authority under which Health Benefits Limited conducts these investigations is section 22G of the Health and Disability Services Act. This section provides that records of claiming practitioners may be inspected and copied to determine whether claims have been made correctly or otherwise.

In many cases certain types of claims may not be made in conjunction with other claims for the same services. It is, however, occasionally necessary to view a patient's records to ascertain whether double claiming is justified. This particularly occurs, for example, when a claim under the maternity benefit schedule is made at the same time and for the same patient as a claim under the general medical services benefit schedule. In the case referred to in Essex's article, claiming patterns for the practitioner concerned seemed inappropriate to both the region and Health Benefits Limited. The police have laid charges against the practitioner, who in due course will appear in court.