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Correspondence

MANAGEMENT OF SUICIDE RISK

DEAR SIR,

May I add my voice to that of Dr Goldney (*Journal*, September 1980, **137**, 303) in urging that we psychiatrists should not abrogate our clinical responsibility for the assessment and management of parasuicide patients. The current fashion of transferring more and more clinical tasks to social workers, community nurses and even, in the case of parasuicide patients, to overworked physicians is to be deplored.

At present, there is conflicting evidence concerning the efficacy of psychiatric intervention; consequently, it would be foolish and possibly dangerous to ignore those investigations in which psychiatric intervention has been associated with a significant reduction in subsequent self-poisoning behaviour (Greer and Bagley, 1971; Kennedy, 1972; Montgomery *et al*, 1979). More research is needed. What is also needed is a willingness on the part of psychiatrists to continue to accept responsibility for diagnosis and management of parasuicide patients.

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DEAR SIR,

Dr R. D. Goldney (*Journal*, September 1980, **137**, 303) is concerned at my view that it is rightly so that the psychiatrist cannot be regarded as the most expert in management of the suicidal. I am happy to explain my position further.

I accept that the psychiatrist must take ultimate clinical responsibility for any such clinical problems under his care. He is the most expert at correlating all aspects of the situation and in deciding on executive action: only he has the necessary breadth of knowledge through his training concerning physical, psychological, social, and behavioural problems, and of course adequate assessment must be based on a synthesis of all these.

Nevertheless, this does not mean that he has an exclusive expertise in clinical management of the suicidal, to which members of other disciplines may contribute their own distinctive skills. A nurse may be best at assessing general behaviour in a ward situation, and a general practitioner or social worker may be more insightful into relationship and social problems. With regard to psychopathology, I have known some highly skilled Samaritan volunteers who seemed to be as expert as anyone else (perhaps more so) at making contact with the suicidal and helping them in their despair. The crucial point is that clinical management must concern the patient as a whole, and this total synthesis is the essence of the psychiatrist's ultimate clinical responsibility. He may exercise this either by direct contact with his patients or in providing consultative advice for other workers.

My original comment was designed to open up rather than close debate on the precise nature and extent of the psychiatrist's expertise and his relationship with others, whether professionals or not, who also provide mental health care. I believe that the psychiatrist's role will ultimately be strengthened if he is concerned with shared rather than exclusive expertise. Management of the suicidal is, of course, a paradigm of a situation in which such debate is crucial.

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THE ISOENZYMES OF CREATINE PHOSPHOKINASE IN ACUTE PSYCHOTIC STATES

DEAR SIR,

Numerous investigations have found elevated creatine phosphokinase (CPK) activity in the serum of

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