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Highlights of this issue

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Suicide – prediction and prevention

There is a strong focus in the *BJPsych* this month on the important topics of prediction and prevention of suicide. Carter *et al* (pp. 387–395) conducted a systematic review and meta-analysis of 39 risk scales used to predict suicidal behaviours, specifically with regard to examining the positive predictive values (PPVs) obtained from studies of these scales. The pooled PPVs for suicide, self-harm and self-harm plus suicide were all found to be too low to support the use of such risk scales as the basis of clinical intervention allocation decisions (ranging from 5.5% for suicide to 35.9% for the combined outcome). The authors propose alternatives to risk prediction stratification, recommending clinical assessment to identify modifiable risk factors and the provision of specific interventions tailored to selected self-harm subpopulations (e.g. those with borderline personality disorder) and to unselected clinical self-harm populations. In a multisite prospective cohort study of adults referred to liaison psychiatry services following self-harm, Quinlivan *et al* (pp. 429–436) found that the seven risk scales considered performed poorly with regard to prediction of repeat self-harm within 6 months (e.g. PPVs ranged from 13% to 47%). They found most scales performed no better than clinician or patient global ratings of risk and some actually performed worse. In a linked editorial, Owens & Kelley (pp. 384–386) comment on the mounting evidence supporting the avoidance of risk scales in clinical practice and instead recommend an individual-based 'needs assessment' approach following self-harm.

Moving from prediction of self-harm and suicide to prevention, Riblet *et al* (pp. 396–402) conducted a meta-analysis of randomised controlled trials (RCTs) of strategies employed to prevent death by suicide. Despite a recent increase in the number of RCTs targeting suicide, most interventions were not found to lead to a significant reduction in suicide events. Three RCTs found that the WHO brief intervention and contact (BIC) approach was associated with lower odds of death by suicide and a number of RCTs of lithium and cognitive–behavioural therapy produced positive but non-significant results. The authors comment on the small size of many trials and limited evidence for generalisability of findings across settings. In a linked editorial, Hawton & Pirkis (pp. 381–383) comment on the limitations of focusing only on the results of RCT-based evaluations of interventions given the likelihood that a broad range of approaches will be needed to prevent a complex problem like suicide across the range of universal, selective and indicated interventions. The authors call on researchers to complement the results of RCTs with findings from studies employing a range of methods and data from a variety of sources, as well as acknowledging that using suicide as an outcome may not be feasible for all intervention evaluations.

Ketamine and electroconvulsive therapy

In a previous systematic review and meta-analysis, increased seizure duration but a lack of efficacy was found for ketamine when used as an ECT adjunct in depression. In an updated review published in the *BJPsych* this month, McGirr *et al* (pp. 403–407) focused on RCTs examining the index course of ECT and specifically considered the role of barbiturate co-administration in limiting the efficacy of ketamine. Overall, the authors found no evidence to support using ketamine over other induction agents in ECT, with the lack of efficacy finding holding true when trials which included barbiturate anaesthetic co-administration were excluded. They also found evidence of an increase in reported confusion associated with ketamine use. In a new RCT of ketamine used as the anaesthetic agent for ECT, Fernie *et al* (pp. 422–428) found no significant differences between ketamine and the control agent propofol on any outcome measure (i.e. depression severity, number of ECT treatments or memory impairment) either during, at the end or at 1 month following the course of ECT.

Treatment following a first episode of mania

Lithium and quetiapine are both considered standard maintenance agents for bipolar disorder but their comparative efficacy and roles at different stages of the illness course are insufficiently understood. In a sample of young people with first-episode mania stabilised with a combination of the two agents, Berk *et al* (pp. 413–421) undertook an RCT of lithium *v.* quetiapine during the maintenance phase of treatment and found an advantage for lithium in terms of symptom levels over 1 year. The authors comment on lithium's role as a 'gold standard' of bipolar maintenance treatment and highlight the particular role for lithium early in the course of illness, in those with severe illness and for those with a manic index polarity.