

so far in the other direction, that psychiatrists find it hard to prescribe the medication even to those who will benefit from its use.⁵ Second, although the main push seems to be towards reduction of antipsychotic use, less is said on how to develop the resources that can provide good non-pharmacological approaches. Audits and targets should not solely focus on the quantity of antipsychotic use in dementia but also on the quality of non-pharmacological approaches available to this population. Long strides are required in this direction to improve behavioural and psychological symptoms of dementia care in the community, hospitals and care homes.

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Authors' reply: We are pleased to see support for our views in the responses received, in particular for the focus on rational debate in this area, rather than an 'either/or' debate. However, we would in reply air the following cautions.

Pattanayak claims that antipsychotics may not be as harmful as we have been led to believe. We would urge caution here. The data produced so far do suggest a reliable and quantifiable degree of harm resulting from antipsychotic use. We do not think that it is truly reasonable, now, to suggest that these drugs may be harmless. But we would also argue that Pattanayak's desire to claim a lack of harm is unnecessary. If they are harmful, their use may be justified under the doctrine of double effect by balancing the likely benefits against harm. It is our clinical experience that the discussions of benefit versus harm with relatives and advocates, informed by the principle of double effect, are effective and well understood.

Finally, we note what is, perhaps, an important slip of the pen in Sekhri's letter. He uses the term non-pharmacological as shorthand for alternatives to antipsychotics. He is correct in saying that there are multiple causes of behavioural and psychological symptoms of dementia. But if we describe all alternatives to antipsychotics as non-pharmacological, we may forget the appropriate treatment of physical illness with analgesics or depression with antidepressants. Alternatives to antipsychotic use in distress include both pharmacological and non-pharmacological approaches. One of us remembers replacing haloperidol for behavioural and psychological symptoms of dementia with effective treatment for scabies. Aromatherapy would have done little here! The term 'non-pharmacological' may therefore distract clinicians and compound a paucity of response to a complex problem.

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Interventions for self-harm: are we measuring outcomes in the most appropriate way?

Kapur and colleagues provide a brief review of contact-based interventions for self-harm and note their continuing appeal, despite largely unconvincing trial results.¹ The question the authors should have posed is not 'How might these interventions work?' but 'Why, when participants report that the interventions are of benefit, are trial results so unconvincing?'

The importance of self-harm lies in its strong association with suicide. The ultimate aim of interventions in this area is to prevent suicide, but the rarity of suicide makes it difficult to use as an outcome measure. Of those studies reviewed by Kapur *et al*, only two used death as an outcome.^{2,3} The remainder used repetition of self-harm, which is the best available proxy measure.⁴

Measuring repetition of self-harm is problematic. Hospital-treated episodes represent the standard measure but fail to capture the true pattern of self-harming behaviour, most of which occurs in secret and does not result in hospital presentation. Those who repeatedly self-harm avoid accident and emergency (A&E) departments at all costs and, when forced by the severity of their injuries to present, are adept at concealing the self-inflicted nature of those injuries, resulting in possible miscoding of visits. There is a need for a reliable, user-designed self-report instrument and a better understanding of the relationship between acts of self-harm and hospital visits.

Hospital-treated episodes do not provide a measure of reduction in self-harm; only a measure of reduction in clinical encounters for self-harm. It is debatable whether reducing clinical encounters is a beneficial outcome for this highly vulnerable and hard-to-reach population (repeat self-harmers). Reducing the number of hospital presentations may cut service costs in the short term; it may not save lives.

In a recent pilot study of a text-messaging intervention for self-harm,⁵ we had an interesting case. One of the participants reported during the trial that the intervention (a text message) had saved their life by interrupting a suicide attempt and prompting them to call for help instead of taking an overdose. They were conveyed to A&E and treated for very severe lacerations. Partly as a result, their visits to A&E increased during the 6-month pilot trial compared with 6 months prior to entry: a negative result using hospital-treated episodes as a measure. Two further participants told us that a suicide attempt had been interrupted by the timely arrival of a text message and begged to be allowed to continue to use the intervention at the end of the trial, yet standard reporting of the results of the study would not provide convincing evidence of effectiveness.

So why are trial results unconvincing, despite qualitative evidence to the contrary? The low status of qualitative data is one possible reason. Another is that we are measuring outcomes in inappropriate ways. We do not yet understand what outcomes are important to those who engage in repeated self-harm, nor how best to measure them.

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