Contact of parasuicide patients with the accident and emergency department

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SUMMARY

In a group of 82 consecutive parasuicide patients attending the St George's Hospital Accident and Emergency Department, London, England, 15 had attended the same department within the preceding 6 months. Thirteen of these 15 had also consulted their general practitioner during this time, as had a further 51 parasuicide patients. Only two out of the 82 patients, therefore, had had sole medical contact with the Accident and Emergency Department in the 6 months prior to their suicide attempt.

This is the first such report from an accident and emergency department. It demonstrates that very few patients seek help from, or visit in isolation, this facility prior to a parasuicide episode as opposed to visiting their general practitioner whose importance is reaffirmed. The problems of identifying 'somatising' patients in an accident and emergency department are discussed.

INTRODUCTION

Patients presenting with parasuicide pose a major problem in health care. The Hill Report on the management of acute self-poisoning in hospital was accepted as policy by the DHSS in 1968 (Ministry of Health, 1968). This policy required the assessment of all parasuicide patients by a psychiatrist. The incidence of self-injury has continued to rise since the early 1970s to the point where some 10% of all acute medical admissions are incidences of self-poisoning (Kessel, 1985). Indeed, the burden imposed by parasuicide on the health service has led to the re-evaluation of the Hill Report (DHSS, 1984), with the recommendation that non-psychiatric doctors with additional training could assess parasuicides.

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Because parasuicide is impulsive in nature (Williams *et al.*, 1980; Birtchnell & Alarcon, 1971; Smith, 1972), the tendency has been to concentrate on secondary prevention (trying to identify characteristics of people at risk for repeat overdose). There is, however, evidence that most parasuicide patients have sought both medical contact and contact with other helping agencies in the preceding weeks (Bancroft *et al.*, 1977). Whilst the most frequent complaints are of anxiety and depression, the patients may present with various physical symptoms (Curran *et al.*, 1980).

In inner city areas, patients often bypass their general practitioners and present directly to the accident and emergency department. To date, however, no work has been published on the pre-parasuicidal contact of patients with the casualty officer. This study was undertaken to investigate the frequency with which these patients had attempted to seek medical help prior to their parasuicide. We were particularly interested to confirm or disprove the subjective impression of many casualty officers that there is a substantial sub-group of parasuicide patients who regularly seek help in casualty departments, without utilising the proper channel of general practice. If such a population were to be identified, we were concerned also to identify any patterns of complaint which might alert us to an impending parasuicide.

PATIENTS AND METHODS

Between 1 September and 31 December 1984, all patients presenting to the Accident and Emergency Department at St George's Hospital with parasuicide were entered into the study. A structural proforma, collecting details of social and/or medical contacts in the 6 months prior to presentation, was completed by the attending casualty officer. Those patients who were admitted were re-interviewed within 24 hours or when fully conscious by the duty psychiatrist or by one of us (MAC). During the period of the study 102 attendances for parasuicide were recorded. Ninety-seven of these were successfully interviewed and a proforma completed. Of these, 92 were first attendances (five attendances were second or subsequent presentations of the same two patients). Ten patients were currently in-patients of the three psychiatric hospitals in the area and were, therefore, excluded from the study. A total of 82 patients presenting for the first time during the study with parasuicide were investigated.

RESULTS

Forty-eight patients were female and 34 male, giving a female/male ratio of 1.45:1. The incidence of parasuicide was highest in the 15–25 age group in both sexes: 59% of females and 41% of males were within this age range.

Only 17 patients (21%) had not sought help from any source in the preceding 6 months. Of the remainder, 65 (79%) had sought consultations with the medical profession and 27 (34%) had had contact with more than one type of practitioner (Fig. 1). Fifty-four (66%) patients had consulted their general practitioner, 30 (37%)

Fig. 1 Distribution of consultation prior to parasuicide.

had consulted a psychiatrist and 15 (18%) had previously presented in the Accident and Emergency Department. Of these 15 who had presented to the Accident and Emergency Department, 13 had also consulted their general practitioner. Of these 13, seven had also consulted a psychiatrist during the study period. Only two patients who had presented to the Accident and Emergency Department had not consulted any other medical practitioner (one of these two patients was not registered with a general practitioner). The method of self-injury was predominantly self-poisoning with drugs. Seventy-three (89%) patients had overdosed: 41 (50%) with benzodiazepines, 24 (29%) with analgesics and 12 (15%) with antidepressants. These were combined overdoses in 15 (19% of patients), complicated by alcohol ingestion in 26 cases (32%) and wrist-cutting in three (4%) cases. Six patients had only cut their wrists and three presented with more violent forms of self-injury.

Of the 15 patients who had attended the Accident and Emergency Department in the preceding 6 months, eight had attended in the preceding 2 weeks and six within 3 months of the parasuicide. Only one attendance (case 15) was more than 3 months before the index presentation. Six patients had attended on more than one occasion.

Six patients were referred on for specialist opinion (three psychiatric) and their characteristics are detailed in Table 1. Those patients not requiring further referral are detailed in Table 2.

Table 1 Characteristics of patients referred for specialist opinion

Case no.	Weeks prior to index assessment	Reason for consultation	Outcome
04	1	Depressed and suspicious	Psychiatric OP
06	1	Chest pain, LVH and cardiomyopathy	Assessed by medical registrar
07	6	'Wanted to see someone'; distressed	Psychiatric OP
09	12	Fell down stairs; scaphoid or splenic injury?	Surgical admission for observation. NAD
11	12	SOB and tightness of breath; o/e depressed	Psychiatric OP
	4	Numbness in neck, face and hands; chest pains	Assessed by medical registrar. NAD
13	26	Abdominal pain, ectopic?	Laparotomy. NAD

Table 2 Details of patients not referred for further opinion

Case no.	Weeks prior to index assessment	Reason for consultation	Local treatment
01	1	Blurred vision following epileptic fit?	Discharged, letter to GP
	4	Drug withdrawal symptoms	Discharged
02	8	Right chest pain: pleurisy?	Erythromycin and aspirin, discharged
	16	Hit on head by son; knocked out	Took own discharge
	26	Burns on right foot	Flamazine and jelonet
03	1	PV bleeding following miscarriage 3 weeks before	Discharged
05	12	Complaining of 'low blood sugar'	Took own discharge
	16	'Collapse', drinking and upset	IV dextrose, discharge
08	7	Itchy right eye, o/e injected	Predsol drops
10	1	Throat pain	Discharged
	16	Tight chest and numb leg	Reassured and discharged
12	2	Upper abdominal pain	Discharged
14	6	Sore right eye, o/e NAD	Discharged
15	12	Chest pain, o/e NAD	Discharged
	21	Painful ankle, o/e NAD	Discharged
	26	Pain left ankle, o/e NAD	Tubigrip and physio.

DISCUSSION

The aim of this study was to investigate the frequency and characteristics of previous

contacts of parasuicidal patients with the Accident and Emergency Department. Our findings do not confirm the commonly held view that parasuicide patients present to the accident and emergency departments in inner city settings having by-passed their general practitioners.

Of the 65 patients who had some contact with medical practitioners in the 6 months prior to their index presentation, only two had exclusively had contact with the Accident and Emergency Department. The overwhelming majority (54) had sought advice from their general practitioner during this time. This confirms the findings of Bancroft *et al.* (1977).

The symptom profile of the potential parasuicide patient in this study gave little hope for early detection in the accident and emergency department. While three patients were noted to be in need of help for their emotional state, the other 12 presented a wide spectrum of disorders ranging from the intensely trivial to suspected major surgical/gynaecological emergencies. As over half of these visits to the Accident and Emergency Department antedated the index presentation by a month or more, they are unlikely to be facets of an identifiable crisis which culminated in the overdose.

In Bancroft's (1977) study, contact with the general practitioner was much closer in time to the overdose (within the preceding month in the majority of cases). The general practitioner's advantage was further strengthened by the fact that most patients complained, at that consultation, of minor anxiety and/or depression. This is unlike their presentations at the Accident and Emergency Department in this study when overt anxiety and depression were rarely mentioned. It is highly likely, however, that some of the more trivial complaints may be linked to the index presentation through intervening variables of the patient's personality, vulnerability or chaotic life style.

The patient with suicidal thoughts may present in a manner more suggestive of organic pathology, masking (consciously or unconsciously) his self-destructive thoughts. The casualty officer must be able to make a judgement about the need for urgent psychiatric attention. He would base this on the patient's morbid thoughts and suicidal intentions, the nature of the parasuicide attempt and the patient's mental state after the attempt. Whilst we consider it important for casualty officers to be alert to, and concerned to enquire after, psychiatric disorders, we are more sanguine about their chances of being able prospectively to identify potential parasuicides.

Thus it would appear from our findings that the general practitioner retains the key role in relation to identifying and helping patients at risk from parasuicide. He is the most commonly consulted and, in addition, he has the knowledge of the patient's social circumstances and personality to which the casualty officer can seldom have access.

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