Clinical Topics

Dealing with the suicidally inclined

E MARGARET PRICE, M W P CARNEY

In England and Wales in 1980 there were 4314 suicides. This figure is probably an underestimate because of the well-known propensities of some coroners to avoid verdicts of suicide and to record them as accidental death and the like. In men and women under 35 suicide is among the top three causes of death and accounts for 10% of all deaths.¹ Parasuicide (those surviving self-poisoning or self-injury) in this age group is the commonest cause of emergency referral to hospital in women and the second commonest in men. Parasuicide is 20-30 times more common than suicide and carries a risk of subsequent suicide 100 times that of the general population in the first year, and this remains raised for 10 years.² An average general practitioner with a list of 2500 may expect a suicide every three to six years and five to six parasuicides annually.

In Harrow Health District (where nearly 500 parasuicides are treated at Northwick Park Hospital every year—all seen by a psychiatrist) it was thought that more effective detection of risk factors and decision-making could reduce the mortality from suicide. A district working party was set up of which MWPC was a member. One of us (EMP) worked as a general practitioner trainee in both hospital and district. Doctors dealing with these patients are often young and inexperienced, whether they are trainee general practitioners, casualty officers, or psychiatrists. Furthermore, we are not aware of any publication giving terse, practical advice on identifying and weighing up risk factors or a "decision-tree" to be followed in management. To remedy these deficiencies we compiled these notes for the Harrow Health District. We hope they may be helpful to others. They are not a treatise on the complex aetiology of suicidal behaviour or on the purely medical management of self-

poisoning or deliberate self-harm. These topics are well reviewed elsewhere. We assume that in most districts, like Harrow, all parasuicides sent to hospital are seen by a psychiatrist who co-ordinates the acute management of the patient once he is out of danger from the physical effects of his self-poisoning or self-injury.

Assessment of this suicide attempt

It is necessary to obtain a history of the events leading up to this suicide attempt. You need to know "why did *this* patient make a suicide attempt at *this* time?" It may be necessary to interview friends and relatives to get the answers. These inquiries may be complex and time consuming and involve the mediation of community nurses, health visitors, and social workers. Obviously a patient's emergency care cannot wait on the results of these discussions so immediate decisions will have to be based on the best information available, incomplete though this may be.

The following questions will help.

- (1) Is the patient sorry that his suicide attempt has failed?
- (2) What is his hope for the future? If none he is at great risk.
- (3) Did he expect to be rescued?
- (4) Did he think his method was lethal? Violent acts such as jumping in front of a train tend to be more serious than taking a few tablets. This rule is by no means absolute, however; psychotic depressives may make an apparently futile gesture with a few tablets.
- (5) Does he think that the precipitating crisis is resolved or resolvable?

Assessment of further suicide potential

- (1) Ask the patient if he still has thoughts of harming himself.
- (2) If yes ask if he has thoughts of killing himself (more meaningful than asking him about wanting to die).
- (3) If yes inquire about the plans.
- (4) Assess the feasibility of these.
- (5) Ask the patient to follow these ideas through. There is more risk if the patient has clear ideas about what will happen after his death—for instance, if he has thought about the effect on his family and friends—than if he does not really expect to die.
- (6) Consider the risk factors (see table).

Harrow, Middx

E MARGARET PRICE, PHD, MB, general practitioner (formerly trainee in general practice, Northwick Park Hospital)

Northwick Park Hospital and Clinical Research Centre, Harrow Middlesex

M W P CARNEY, MD, FRCPsych, consultant psychiatrist

*Factors that increase the risk of a further suicide attempt***General factors**

Previous attempt
 Family history of suicide
 Alcohol and drug abuse
 Older, single, unemployed man
 Restricted personality with few assets, personality disorder
 Psychiatric illness—depression and schizophrenia
 Chronic or terminal illness
 Recent separation from a loved one, bereavement
 Socially isolated or lonely circumstances
 Inadequate family or social support
 No personal philosophy or beliefs
 Easy access to drugs

Present factors

Severe feelings of hopelessness or worthlessness
 Severe insomnia
 Agitation and restlessness
 Depression, schizophrenia
 Recent suicidal attempt
 Manner of suicide attempt (see text)
 Voices telling him to harm himself

(7) Evaluate your own reaction. Do you still think that the patient is suicidal, whatever information has already been gathered? What do the nurses think? They may have had prolonged contact with the patient.

Action in general practice

The family doctor often has the advantage over the hospital doctor of already knowing the patient and of having formed a therapeutic relationship with him. A suicidal patient needs time to talk and the opportunity should be seized, even at the risk of delaying other surgery business. If admission to hospital seems unnecessary emphasise to the patient that he can always contact you (or another doctor out-of-hours) if he feels worse. Warn the people on your rota that this may happen. Before leaving the patient should be given a further definite appointment.

The decision to admit or not may be clarified by a home visit, where the family may be consulted and their resources assessed. Lack of support makes admission more advisable. If in doubt contact the local psychiatric unit and speak to the psychiatrist. Direct admission, a consultant domiciliary visit, or intervention by community psychiatric nurses may be arranged. Other members of the primary health care team—for example, the health visitor—can also help. You should be careful, however, that the patient does not misconstrue this as a rejection on your part or that manipulative individuals do not play one agency off against another.

If you are called to someone who has apparently attempted suicide besides carrying out the usual examination look for circumstantial evidence, such as a suicide note or drug or alcohol bottles. If you decide to send the patient to hospital make sure that these together with your letter accompany the patient. Remember that people may try two ways of killing themselves simultaneously—for example, exhaust gases and an overdose of pills.

Action in hospital

If you are in doubt discuss with the registrar or the consultant on-call via the switchboard. Make sure that the patient is not still in danger from the physical effects of his self-poisoning or self-injury.

IF STILL SUICIDAL

The patient must be admitted for close observation and treatment, where appropriate. Make sure the nurse-in-charge realises that the patient is a suicide risk.

Where?

If there is a catchment area admit to one of the local psychiatric wards. If there are no beds you may, in consultation with the duty nursing officer, be able to work out some sort of internal arrangement. If not it may be possible to hold the patient in the casualty observation ward, provided that their staff are agreeable, until a bed can be found. Failing this, your hospital may have an arrangement with another hospital to take the overflow of patients.

If the patient does not come from the catchment area contact the

duty doctor of the appropriate psychiatric unit (details should be available at some central spot in the hospital). If there are no beds in this unit the patient may have to be admitted to your hospital until a transfer can be effected.

How?

Most patients will not object to informal admission, but if a patient refuses he may, as with other psychiatric emergencies, require compulsory detention under the Mental Health Act. There are two requirements: (1) the patient is suffering from a mental disorder, and (2) he requires detention for his own (or another's) safety. Sections 25 or 29 are usually invoked. Section 29 requires two signatures, one from a social services officer, or a relative and the other from any registered doctor. This lasts for 72 hours. It may then be converted to section 25 which requires a second medical application and lasts for 28 days. For section 25 one doctor must be approved under the terms of the Mental Health Act and both doctors may not be on the staff of the same hospital. A hospital must be willing to accept the patient.

IF THE PATIENT IS NO LONGER SUICIDAL

If he has a psychiatric disorder—for instance, depression, alcoholism, or schizophrenia—admission may still be appropriate. Alternatives are attendance either at a day hospital or at an outpatient clinic. If you decide not to admit get in touch with the general practitioner. Tell the patient to call someone he can trust—for instance, his general practitioner, hospital social worker, Samaritans, or a friend—at any time if suicidal thoughts recur or if his distress deepens. It may be a good idea to give the patient the local psychiatric community nurse's telephone number.

If the patient has no treatable psychiatric disorder

(1) Modification of his social environment may be feasible. Consider referral to the general practitioner, social worker, or health visitor.

(2) Counselling may be effective—for example, from a social worker, general practitioner, priest, minister or rabbi, marriage guidance counsellor, or employment adviser.

(3) The family and friends may be able to offer more support. Whether the patient is psychiatrically disordered or not, he may be helped by introduction to a friendly group such as the local Amity group, linked with the Samaritans.

If you are in doubt

Some patients do not seem to fit neatly into any category. Often they have no treatable psychiatric disorder and they are possibly manipulating you. A decision in these circumstances is difficult. It is helpful to discuss the problem with someone who has had more experience.

If you are still doubtful it may be better to admit the patient for a short period of observation. A day or two on the ward may clarify the situation. Remember that many people die from suicide, and you may have to attend the coroner's court if a suicide occurs. You will not be thought negligent, however, if you have acted sensibly in good faith and have shown due care.

Discussion

The motives for parasuicide are several and varied. It may be an attempt to destroy oneself, communicate a need, manipulate a situation, gain a respite, or let fate decide ("Russian roulette" or "dicing with death"). It may also be a self-aggressive act or a sign of mental illness. Most parasuicides do not have treatable psychiatric disorders, but many are depressed or alcoholic, and most can be helped by medical or social agencies. In contributing to a district plan for coping with parasuicide, we became aware of a central dilemma. Medical resources alone cannot cope with the sheer size of this problem, though doctors, understandably, may feel guilt at being unable to do so. Nevertheless, there needs to be effective co-ordination of both medical and social efforts to help, by the consultant at hospital level and the general practitioner in the community. Clear guidance

needs to be provided for doctors and other workers likely to encounter these patients. Self-help organisations, such as the Amity groups, should be encouraged. Suicide is an eminently preventable cause of death, and we believe that prompt intervention and accurate assessment of the situation may save lives.

We thank Dr Nicol Ferrier and Dr Selina Gellert; the members of the Harrow District Planning Team on Attempted Suicide; staff of the psychiatric unit, Northwick Park Hospital; and Mrs Monica Williams.

Requests for reprints to: Dr M W P Carney.

References

- ¹ Office of Population Censuses and Surveys. *OPCS Monitor*. (DHZ 80/3). London: OPCS, 1980.
- ² Kreitman N, Dyer JAT. Suicide in relation to parasuicide. *Medicine* 1980;**36**:1827-30.

(Accepted 11 June 1982)

Contemporary Themes

Long-stay care for elderly people: its continuing evolution

J S RODGERS, J A MUIR GRAY

The recognition that the changing age structure of society, with an increasing number of old and dependent people, will pose one of the major problems confronting social policy for the next 20 years has come lately to the public conscience. Even now it is an issue acknowledged more in the proclamation than in action at a national level, whether by government or by professional bodies. And yet services are inadequate, and the problems that ensue are on us.

The inadequacies are most apparent in institutional care, the two major issues being those of misplacement of people and the gaps between the types of provision. Both relate to former philosophies that underpin the provision of hospitals and of old people's homes. There is an adherence to roles that grew up many years ago, and which have never been revised.

In institutional care people are either residents or patients. In each case there are expectations about how they will behave, what they will demand, and, especially, how they reinforce the part staff expect them to play. If the old people do not conform to the correct image they are judged misplaced. In geriatric hospitals there are many patients who should be residents, or at least who should be elsewhere; in old people's homes there are residents who should be patients in hospital, while in both there are those who should be in psychiatric hospitals, inevitably the resources in shortest supply. The spheres of each type of institutional care overlap considerably, while each institution describes for itself a well-defined boundary that is not contiguous with any other.

This demarcation also creates gaps, into which fall the "too fit but too frail," too fit to be in hospital but too frail for an old people's home. An individual so identified is not thought to require the resources and skills of a hospital, but because of physical or mental disability is beyond the responsibility of the old persons' home.

Why should this have come about? Services for old people have been provided by the State for many years. Is it not reasonable to suppose that the roles of institutions should have

been redefined with some common purpose? This certainly has not happened, while the current emphasis in national policy, towards community care, has paradoxically highlighted the need for such a step. Domiciliary services have expanded, and steadily improved both in quality and quantity in order to keep people at home. When this is no longer possible, the old people concerned have reached such a level of dependency that they do not fit into either of the two main types of institutions. Add to this the equally praiseworthy move of hospital care towards rehabilitation, away from asylum and long-stay care, and the central issue is magnified, and continues to grow.

All this is the end result of many years of pragmatic policy-making, during which the least desirable have been excluded from the system. At first, the "incurable" were excluded from the voluntary hospitals¹ and had to be looked after in workhouses. Then the disabled, or the difficult and thus less deserving, were segregated into workhouse infirmaries,² where they languished. Neither the disappearance of the boards of guardians in 1930,³ nor the involvement of the wartime emergency medical services, changed this. In 1947 people were still sent to the workhouse infirmary if they failed to conform.⁴

Pushed always to the end of the line, out of sight, the disabled elderly might have expected a change in fortune in 1948 with the advent of the National Health Service. Even then they were forgotten. The rapid dismantling of the old system demanded easy dividing lines; those in wards looked after by "nurses" became the responsibility of the hospital service, while the rest of the workhouse residents were to be looked after by the new old people's homes, provided by local authorities and envisaged by Aneurin Bevan as providing the working-class equivalent of the residential hotels much beloved by the middle classes in the '20s and '30s.⁵ Appropriate levels of care or types of resident to be admitted were not defined. Nursing care, whatever that might mean, became the criteria for allocation to the Health Service. Personal care in the local authority home was to be provided only to the level that a relative would provide in one's own home.

This definition remains to the present day. It was last emphasised by DHSS in 1977 in the Purple Book on residential care.⁶ Despite almost 30 years, the respective roles of hospitals and old people's homes had not been reexamined, while the problems multiplied. The attitudes of the nineteenth century seem to have been implanted in the policy makers of today.

Oxfordshire Area Health Authority (Teaching), Headington, Oxford OX3 9DZ

J S RODGERS, MB, FFCM, community physician
J A MUIR GRAY, MD, MFCM, community physician