A follow-up of self-poisoned patients

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SUMMARY. Over half the patients who were admitted to hospital after self-poisoning had seen their general practitioner in the previous month, and in half of those discharged from hospital no definite after-care arrangements were made. Opportunities for prevention of occurrences are being missed. Thorough follow-up of 135 such patients identified many non-medical problems, and over 80 per cent were helped by appropriate referral. Although only five of these patients made a further attempt during the period of review, the method of selection of patients does not allow definite conclusions to be made.

Introduction

IN Great Britain it is estimated that at least 100,000 people are admitted to hospital each year as a result of an overdose of drugs, and they probably cost the NHS at least £5m a year (Jones, 1977).

Up to 40 per cent of patients have a history of a previous episode and between a fifth and a quarter make a further attempt within a year (Chowdhury *et al.*, 1973). In only about ten per cent of these patients is a definitive psychiatric label appropriate—the vast majority are not mentally ill (Kessel, 1965). These patients have many social problems, including living in overcrowded conditions and alcoholism, and yet many are discharged from hospital with little attempt at follow-up. I report a follow-up study by a general practitioner in which all patients who were not being reviewed by psychiatrists or physicians were offered outpatient after-care.

Method

The fate of 100 patients who presented to an accident and emergency department after self-poisoning was identified from the casualty register and inpatient notes.

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The default rates from psychiatric, general medical, and surgical outpatient clinics were estimated by examination of a large sample of clinic bookings. All patients admitted to the Royal Infirmary, Sheffield, between January 1974 and June 1975 with self-poisoning who were thought not to need psychiatric follow-up were offered an appointment with a general-practitioner clinical assistant in the medical outpatient department. It was planned to see the patients at intervals of two weeks, one month, three months, six months, and one year after admission, or more often if this was clinically appropriate. At the initial interview the patient was questioned in depth about his background, social circumstances and environment, premorbid personality, and precipitating stresses.

The modified Beck depressive inventory (Beck and Beck, 1972) and Orme questionnaire (1965) were used to check clinical opinion and to quantify progress. Patients who were thought to require psychiatric attention were referred to a psychiatric clinic.

General practitioners were also asked to complete a questionnaire designed to investigate the frequency of doctor-patient contact and the doctor's assessment of the patient's vulnerability.

Results

Ninety of the 100 patients attending the casualty department were admitted to hospital. Twenty-six patients were considered in need of further psychiatric care, either as inpatients (11) or as outpatients (15). Only nine patients were given appointments to attend medical outpatients, and in over 40 cases no definite arrangements for follow-up were made.

Between January 1974 and June 1975, 600 patients suffering from a drug overdose were admitted to the Sheffield Royal Infirmary. One third were thought to require further psychiatric care and were followed up by a psychiatrist. Most of the remaining 400 were offered an outpatient appointment at the general-practitioner clinic. Of these, 146 accepted, although only 99 eventually attended the clinic. This default rate of 32 per cent compared with a rate of 40 per cent among the overdose patients attending the psychiatric clinic. The

general default rate from the psychiatric clinic was 17 per cent, while the total default rate from the medical and surgical clinics was only nine per cent.

Of the remaining patients, 41 were eventually interviewed at their homes, so that 96 per cent of those patients initially willing to be interviewed were seen. Five patients were thought to be suffering from definite psychiatric disturbance and were referred back to a psychiatrist. Of this group, consisting of 135 patients, 84 were women and 51 were men. Their mean age was 23·7 years and the ratio of females to males was 1·64. One fifth of the married women were either separated or divorced. A third of the patients were living in privately owned housing and 56 per cent in local authority housing. Over 60 per cent were from social classes 4 and 5, and only 15 per cent were from classes 1 and 2. Five patients gave a family history of mental illness, and the father of one of the men had committed suicide. A quarter of the patients had a history of a previous episode of self-poisoning and one third had had previous psychiatric treatment.

The principal precipitating factor was disagreement with the sexual partner, often of a trivial nature, and three quarters of attempts followed such an incident. Four fifths of the patients took the overdose in their home (82 per cent while alone), although three quarters told a relative or friend within 30 minutes of doing so.

The overdose was impulsive in 80 per cent of patients. Half the patients had taken alcohol shortly before or at the time of the overdose and one fifth of the patients had previously threatened that they would take an overdose. A third of the patients thought that the overdose had achieved the desired effect and produced an improvement in their circumstances.

Many patients had problems which required non-medical help. Nearly half the women were advised to seek the help of the Marriage Guidance Council, although only 19 actually did. Eleven men had definite problems with alcohol and were encouraged to seek the help of Alcoholics Anonymous. The aid of a social worker was enlisted in 30 cases, and the housing department contacted in 28. Other sources of help included the Samaritans, the home nursing service, and meals on wheels in providing care for dependant relatives. One young man required regular and lengthy support because of a drug problem and another because of his homosexuality. Although one third of the men had said that they were worried about money, it was unusual for the women to admit to financial problems. In all, over 80 per cent of patients were put in touch with an appropriate source of help.

Although there was good agreement between the Beck depressive inventory and the Orme questionnaire, many patients about whom there were grounds for concern did not produce significant scores using these methods. On their first visit, over one third of the patients interviewed had scores on the Beck depressive inventory in the moderate or severely depressed range. When questioned about their motive, 40 per cent of the patients said that they had intended to die, although almost half were quite sure that they had no such intention. When interviewed a month after the episode, 62 per cent were glad to be alive, while 18 per cent wished they were dead, and 12 per cent claimed that they would make a further attempt.

One year after the episode, most of the patients were feeling better, and in 82 per cent of cases this was confirmed objectively by a reduction in their score on the Beck depressive inventory and the Orme questionnaire. During the follow-up period of up to two years, only five patients (3·7 per cent) made further attempts. This contrasts with repeats in 27 per cent of those patients who declined an outpatient appointment and 39 per cent of those who were attending the psychiatric outpatient department. One patient, a psychopath with numerous previous episodes, had already been referred back to a psychiatrist, while another young man took about 20 paracetamol tablets about two weeks after a diazepam overdose. He told no-one about it and presented at his general practitioner's surgery with jaundice about four days later.

Forty per cent of patients had consulted their doctor within the week preceding the overdose, two thirds of the patients had seen him within the previous month, and 80 per cent within the previous three months. In the year preceding the overdose, the average number of visits to the family doctor was 8·5, and during the year after the attempt the average rate of attendance was 10·4. The doctors classified only one third of the patients as vulnerable personalities. The drug involved was prescribed by the doctor in only one third of cases, a further third had consumed tablets belonging to a relative or friend, while the remaining third had taken drugs which were freely available without prescription. One year after the overdose, over a third of the patients were still receiving regular prescriptions for the same drug which led to their admission to hospital, and half were receiving intermittent treatment with either tranquillizers, antidepressants, or hypnotics.

Discussion

Self- poisoned patients impose a considerable strain on medical resources and are responsible for over ten per cent of emergency admissions and a third of all medical admissions (Jones, 1977).

Most of these patients appear to have had recent contact with their general practitioner and one wonders if opportunities for prevention are being missed. The majority have taken prescribed drugs, although in half the cases the drug had been prescribed for someone else. Great care is needed in prescribing psychotropic drugs, as the free availability of these drugs in the community appears to be one of the principal factors in the growth of self-poisoning to epidemic proportions (Smith, 1972).

It is worrying that a year after the overdose a third of the patients were still receiving regular prescriptions for

the drug responsible for the overdose.

The causes of self-poisoning lie more in sociology than in medicine. Overcrowding, bad social conditions, and unsatisfactory relationships are the breeding grounds (Kessel, 1965). The patients have been dealt a poor hand and are not good at making the best of it.

It would be wrong to conclude, because so few patients made a further attempt, that the after-care programme was a success. It is much more likely that the psychiatrists were successfully detecting those most at risk by following up the patients about whom they were most concerned. Those patients who declined offers of help may have done so because they thought they did not need it, or thought we could not help.

The high default rate of these patients from after-care clinics may be more a reflection of our ineffectiveness in the patients' eyes than of the basic irresponsibility of this group of patients. At least the patients who attended the general-practitioner follow-up clinic could feel that someone was interested and prepared to try and help. They were not left without support.

Several risk factors which predispose to repeated episodes of self-poisoning have been identified (Chowdhury *et al.,* 1973). These include depressive illness, psychopathic personality, previous psychiatric treatment, alcoholism, drug addiction, and homosexuality.

Over half the patients are discharged from hospital without definite arrangements for their after-care being made. Although their problems are largely non-medical, their 'cry for help' has made them the doctor's responsibility. It is a responsibility which he cannot lightly shrug off. It is important to identify these patients' needs, arrange appropriate referral, and provide the basic psychotherapy, which is often nothing more than a shoulder to lean on. The patients need the doctor's time and thought, and not his drugs! The doctor cannot mend an unsatisfactory marriage, but his very silence may be both diagnostic and therapeutic.

The general practitioner who so unwittingly provides the means for the overdose must accept responsibility for the identification of at-risk patients and for the after-care of those especially at risk, and must unavoidably act as co-ordinator of helpful professional and lay services.

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