Self-poisoning and the general hospital

In this issue, Bialas and colleagues from South Wales have highlighted several important aspects concerning recent trends in deliberate self-poisoning. Their findings are largely in keeping with those in published and unpublished reports from several other centres in the UK. These trends have important implications for general hospital services, especially general medicine and accident and emergency departments.

Bialas and colleagues indicate a substantial rise in the number of self-poisoning patients and episodes referred to their district poisons unit. There is evidence that, following a decline in rates during the 1980s, this increase is happening elsewhere in the UK, including Scotland and Oxford; an informal survey of colleagues indicates that the trend is widespread. It is unclear why these substantial changes should have occurred, just as we do not know the reason(s) for the decline in rates in the 1980s. That the increase is most marked in young males perhaps provides us with a clue. This is in keeping with the recent pattern for completed suicide, where an escalation of rates in young males has occurred in the past decade. Several explanations for this have been put forward, including declining prospects for satisfying employment, increasing rates of alcohol and drug abuse, psychological consequences of increased parental divorced rates (although in theory females should be just as affected), AIDS, increased ability of females to leave unsatisfactory relationships and live independently, and, perhaps most pertinently, a general alienation of many young males within our society.

This pattern is placing much greater demands on already stretched general hospital services, including accident and emergency departments, inpatient clinical teams and general hospital psychiatric services. Most importantly it means a general increase in demands on general hospital beds and must be one factor contributing to the current bed crisis.

Another important trend highlighted by the report from Bialas and colleagues is the increasing use of paracetamol for self-poisoning. The considerable risk of hepatotoxicity means that all cases in which paracetamol use has occurred or is suspected must be investigated and this usually requires admission. Measures to reduce the risk of paracetamol self-poisoning are a priority need. Recent research suggests that availability is the key factor and that reducing the amount available per preparation could be useful first step. Other European countries, most of which have much more restrictive policy than is the case in the UK, do not have the same problem, and especially nothing like the degree of mortality from this cause. Side-effects may limit the usefulness of adding methionine to paracetamol to protect against liver damage. There is no evidence that blister preparations have any preventive effect in terms of reducing the likelihood of overdose; however, blister-packing plus fewer tablets per preparation seems a sensible combination. Correcting the commonly held belief that an overdose of paracetamol causes immediate unconsciousness might also help; carefully-worded warning labels might be one means of doing so, although there is some doubt that warning labels would make any difference. In addition, the prescribing of the paracetamol-dextropropoxyphene combination (e.g. Coproxamol) requires great care, since this preparation seems to contribute to a surprisingly high proportion of actual suicides. Whether these deaths occur in people for whom it is prescribed or in others in their households is unclear.

Bialas and colleagues also highlight the well-recognized high rate of repetition of self-harm and of psychiatric disorder, including alcohol dependence, in the self-poisoning population. In spite of their indicating that most cases did not appear to be associated with serious suicidal intent (although this had increased in their more recent study period), the risk of suicide after self-poisoning or self-injury is considerable, with at least 1% dying in the first year, this figure representing a 100-fold excess risk over that of the general population. The risk continues to be relatively high even several years later. A history of repeated attempts, psychiatric disorder and substance abuse (especially in adolescents and young adults) are some of the more important factors that indicate risk of eventual suicide. The mental health section of...
The Health of the Nation includes a general suicide prevention target which is a reduction in the overall suicide rate in England and Wales by the year 2000. Self-harm patients are clearly a most important population on which to focus preventive strategies. It is essential that all general hospitals have a properly staffed and responsive psychiatric service that can provide assessment and aftercare for as many of these patients as possible. Department of Health guidelines published in 1984 and which remain operational highlight the need for psychosocial assessment of these patients and also recognize that properly trained non-medical members of psychiatric teams can be a highly important resource for this work. General hospital doctors working in A&E and medical settings should do all they can, together with their psychiatric colleagues, to lobby purchasers for establishment of adequate services where these do not already exist. The Royal College of Psychiatrists has recently published guidelines for the requirements of such services. This document should prove invaluable for doctors who wish to negotiate with purchasers in order to ensure adequate provision is made for this rapidly growing patient population.

It is sometimes said that there is no evidence that specific psychiatric aftercare of patients who self-poison is effective. This is not so. First, there is a subgroup of patients with major mental illness, particular depression, schizophrenia and anxiety disorders. A range of treatments of well-proven efficacy are available for these disorders. Secondly, there is the substantial group of patients, many of whom have psychiatric symptoms, but for whom social problems, especially relationship difficulties, employment problems, family disruption and social isolation, are the main source of distress. There is accumulating evidence that psychosocial treatment can be effective in terms of problem resolution and general social adjustment, especially for females. Whether repetition of self-harm can be prevented is more controversial, largely because estimation of the effects of treatment on this important variable has in virtually every study been undermined by inclusion of too few patients and hence inadequate power. However, there have been promising results and the trends in most studies have been for lower repetition rates where a specific treatment approach has been provided and compared with treatment as usual, or minimal treatment. This is an area where a large and hence probably multicentred treatment study is urgently required.

However, total responsibility for helping these patients should not rest with psychiatric teams only. As the document from the Royal College of Psychiatrists also emphasizes, basic skills in assessing suicide risk, psychiatric disorder and immediate needs in these patients should be acquired by medical and nursing staff in all A&E and general medical settings. It must not be forgotten that, after realizing that a suicide attempt has failed, a highly suicidal patient may not wait around for a member of the psychiatric service to arrive, and that immediate suicide prevention may then be the responsibility of whoever is available at the time to assess the patient.

K. Hawton
University Department of Psychiatry
Warneford Hospital
Oxford

References