Patients seen early or without appointment

Sometimes early attendance occurs because a patient has problems. Such requests are taken seriously as they may indicate the onset of relapse.
These frequencies were:

Period X	33 (20)* leading to one admission
Period Y	13 (7)* leading to two admissions

As frequent attendances in Period X led to only one admission as against two admissions after fewer attendances in period Y, it would seem that this procedure may be an effective means of forestalling admissions. Patients' confidence in the usefulness of early attendance may have been undermined in Period Y when they did not know whom they would see at the clinic.

Comment

The significant increase in admissions for clinic patients during Dr C. A. B.'s absence supported the hypothesis that schizophrenia sufferers whose psychiatric management remained in the hands of an experienced and trusted clinician, who knew them well, were less likely to relapse than when their management was in the hands of unfamiliar doctors. The data regarding missed appointments and early attendance underline the extent to which the experienced clinician was able to respond flexibly to known patterns of behaviour, in a way that was impossible for colleagues unfamiliar with the patients. The great reduction in requests for an early appointment during Period Y suggests that patients may have been less prepared to approach the services when they knew that Dr C. A. B. was not available, although an early appointment might have circumvented a relapse.

Service planners could therefore usefully take into account the beneficial effects of continuity of management when considering maintenance of patients in the community.

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Innovations

Quality assurance and parasuicides presenting to casualty departments

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In view of concern regarding rising youth suicide rates, suicide being a critical event in increasing emphasis on clinical accountability, I conducted a quality assurance exercise in relation to casualty department assessments of parasuicides. While much has been written in the area of suicide assessment and rating scales, I found nothing adequate for my purpose. Accordingly, I present a format for conducting such an exercise with the aim of providing suggestions as to which clinical assessment items

might usefully be emphasised in future clinical assessments. It has been designed solely to guide this process with no attempts to estimate reliability or validity.

The setting

The working atmosphere of casualty departments may change by the minute, from tranquillity to chaos. At times there may be a queue of urgent cases necessitating brief assessment which may only be triage orientated. In addition, such patients may be unco-operative offering limited information. Without knowledge of the degree of environmental chaos and patient co-operation, it would be unwise to draw too many conclusions about adequacy of assessments from examination of individual charts. However, it may be possible to compare the frequency of assessment of individual variables. For instance, if variables X and Y are equally important but variable X is assessed consistently more frequently than variable Y it can be inferred that greater attention might be paid to variable Y.

Format

The aims are to evaluate the relative frequency of documentation of individual history items relevant to the assessment and disposal of parasuicides; and to provide feedback for improvements in the assessment, and documentation of cases.

A minimum of 20 cases (50 being ideal) should be randomly or consecutively selected for chart review by way of a register. The points to be considered are whether clinicians have considered and documented items with no attempts being made to determine the accuracy of those considerations. Repeating parasuicides are assessed once. Inspection should be performed by two clinicians who should negotiate over discrepant interpretations of case-notes. Items on the assessment sheet (Appendix 1) should be rated for being recorded in a recognisable form or not recorded in a recognisable form.

For all items, the frequency distributions are then determined so that items can be compared with each other. While all items may be relevant, it is often not possible to state whether they were considered. For example, if there is a detailed family history suggestive of good relationships, it might be unreasonable for the clinician to make further specific inquiry about sexual abuse. However, without specific documentation it would be incorrect to state that this item has been noted. Hence, for some items it would be unreasonable to expect them to be recorded all or even most of the time. For others, e.g. what tablets were taken, it would be reasonable to expect this to have been done 100% of the time. Readers are invited to determine their own ideas about the frequency with which items should be noted. To assist the reader in determining frequency levels for inter-item comparison, description and discussion of the individual items follows. For reasons of brevity and the recognition of the experience of readers of this journal self-evident issues will not be discussed.

The items

"Who was on admission" permits checking regarding implementation of policies, i.e. the proportion of parasuicides that are psychiatrically assessed by psychiatrists, registrars, social workers or not at all. "Length of history" provides a broad statement of quantity of information. If patients are interviewed more than once duplication may partly invalidate this item.

Description of parasuicides

These items describe the circumstances of the parasuicidal act for assessment of suicidal intent and an understanding of the motivation.

Items 1–8. Assess the lead up to the act and reflect intent.

Item 2. "Duration ideation" might be inquired by way of question (Q): "How long have you been thinking of harming yourself?".

Item 3. "Frequency", e.g. (Q): "You say that you have been thinking about suicide for the last (e.g.) ten days (duration): how frequently during that time have you thought about suicide?".

Item 4. "Goal" – e.g. (Q): "What did you hope the outcome of harming yourself to be?".

Items 5–8. Relate to preparations for suicide and precautions taken to avoid being rescued.

Item 9. "Intoxication" relates to disinhibition due to alcohol and drugs. Alcoholism is commonly associated with parasuicide (Hawton *et al.*, 1989). It has been usually suggested that the life time risk of suicide in alcoholics was between 11–15% (Miles, 1977). However, this has recently been challenged suggesting a risk of 2.3–4% (Murphy & Wetzel, 1990). Regardless of this alcoholics are at greater risk of further parasuicidal behaviour and have high rates of general health care utilisation.

Item 10. "Precipitant". The majority of parasuicides involve predisposing (vulnerability) and precipitating (the insults bringing on the crisis) factors. Precipitants may be missed by inexperienced clinicians yet are vital for understanding crises.

Background

Items 11–12. "Past psychiatric history" and "past parasuicide" provide information for prediction of future coping behaviours and assisting diagnoses.

Items 14–15. "Drug and alcohol abuse" are common concomitants of parasuicide and are associated with a poorer prognosis.

Item 16. "Forensic" relates to past criminal and violent behaviour which may be associated with parasuicide and present difficulties to therapeutic relationships.

Family (of origin)

Item 17. Description of family members – a minimum requirement would be the description of two parents and the presence or otherwise of siblings.

Item 18. "Atmosphere" relates to the colour of family relationships, e.g. violent, detached, overprotective, etc. Family violence and parental arguments in particular are associated with suicidal behaviour in offspring (Pfeffer, 1989).

Item 19. "Supportive/unsupportive" relates to some description of whether relatives provide reasonable support. This may not concur with item 18: e.g. "We seem to argue a lot but my parents really care".

Item 20. "Child abuse", past child abuse has been found to be three times more common in 13–17 year old female parasuicides than other casualty department attenders (Deykin *et al*, 1985). Parasuicidal acts provide an important opportunity for screening for abuse which may have contributed to the parasuicidal act. Similarly a pre-existing history of concerns regarding child abuse has been found in 29.8% of mothers attempting suicide (Hawton *et al*, 1985).

Future risk

Item 22. "Biological features" relates to physiological features of affective disorder.

Item 23. "Psychotic symptoms". Clinicians may be so absorbed with crisis issues that they forget to ask regarding psychotic symptoms. The presence of these will often necessitate a substantially different management strategy, e.g. admission.

Items 25–26. "Ongoing ideation" and "ability to resist" are important both clinically and medico-legally. Statements by the patients that they feel they can contain their suicidal impulses may be reassuring and beneficial to the therapeutic alliance. Medico-legally informed consent requires patients to be informed and contribute their ideas on preferred management – even if the clinician decides to reject these ideas.

Item 27. Gun/availability of method. If a patient has considered his preferred means of suicide, e.g. gun or antidepressant tablets and has these available, the risk rises.

Collateral

Item 28. "Family". Collateral information from the family may differ from the patient's account altering the envisaged risks and/or shedding light on the underlying problems. The delivery of collateral may provide observations relating to family atmosphere.

Item 29. "Other care giver". If a patient has had recent contact with clinicians regarding psychological problems prior to a parasuicide, these clinicians should be invited to share their longitudinal observations at a time of a cross-sectional assessment.

Disposal

Item 30. "Follow-up arrangements" relate to who will assume responsibility for follow-up of the case.

Item 31. "Length of time until follow-up". Parasuicides occur during crises and as such require early follow-up. Recording how soon the patient is booked to be seen permits review of whether this is being practised.

Item 32. "General practitioner/other advised" relates to advice regarding assessment and disposal being relayed to general practitioners and others, e.g. ongoing psychiatrists who assume responsibility for a high risk management task and may be at risk of providing drugs for further overdoses.

Conclusion

A format is presented for conducting a quality assurance exercise relating to psychiatric assessment of parasuicides in casualty settings. Despite practical limitations imposed on historical data gathering, this exercise can provide guidance regarding areas worthy of upgrading clinical inquiry. Repeated over a period of years, it might promote the evolution of histories that reliably inquire regarding factors associated with lethality of intent, background issues including associated pathology, family

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problems and ongoing risk, providing a better basis for interventions.

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Appendix I

Quality assurance
Assessment/management of parasuicide casualty settings
= noted in recognisable form
× = not recorded or recognisable

Name: .....

File no: .....

Date of birth: .....

Date of presentation: .....

Time of presentation: .....

Who saw on admission: (medical only/psychiatric residents/psychiatric registrar/psychiatric resident and registrar/psychiatrist + others) .....
.....

Length of history (pages) .....

Description of parasuicide		
Tablets/other means	( )	1
Duration ideation	( )	2
Frequency	( )	3
Goal	( )	4
Note	( )	5
Background		
Past psychiatric history	( )	11
Past parasuicide	( )	12
Medications	( )	13
Family (of origin)		
Description of members	( )	17
Atmosphere	( )	18
Future risk		
Biological features	( )	22
Psychotic symptoms	( )	23
Ongoing ideation	( )	24
Collateral		
Family	( )	28
Other care giver	( )	29
Preparations	( )	6
Who with?	( )	7
Where?	( )	8
Intoxication	( )	9
Precipitant	( )	10
Drug abuse	( )	14
Alcohol abuse	( )	15
Forensic	( )	16
Supportive/not supportive	( )	19
Child abuse	( )	20
Family psychiatric history	( )	21
Ability to resist	( )	25
Plans for future	( )	26
Gun/availability of method	( )	27
Disposal		
Follow-up arrangements	( )	30
Length until follow-up	( )	31
General practitioner/ other advised	( )	32

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