

PRACTICE OBSERVED

Practice Research

Patterns of consultation and parasuicide

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Abstract

Parasuicide is common; its treatment depends on its prevention, which in turn depends on accurate identification of those at risk. When the rates of consultation and the number of prescriptions issued each year for patients who had survived parasuicide were compared with those for controls matched for age and sex the patients who had survived parasuicide were found to have attended much more frequently; their pattern of attendance had accelerated up to the time of the attempt and then decelerated. This variation was not seen in the control group. The number of prescriptions received per visit was static in both groups at all times.

General practitioners should regard more frequent attendance by patients who already attend often as indicating that those patients are at risk of parasuicide.

Introduction

Parasuicide has been defined as a non-fatal act whereby a person deliberately causes self harm¹; most people who deliberately harm themselves do not wish to die.² Parasuicide accounts for 10% of all acute admissions,³ and the total number of cases in Britain each year is thought to be about 100 000.⁴ Self harm shows a person to be in conflict with himself and his environment, and it both reflects and is encouraged by the values of contemporary society.⁵ The prevention of parasuicide lies in identifying groups at risk, but, despite many excellent studies,^{6,7} most research has been based in hospitals. A study based in general practice should provide an accurate measure

of the prevalence of parasuicide in a community, and general practitioners' records are unique in that they contain much information that may be relevant to the aetiology of parasuicide.⁸

Patients and methods

By using the age-sex register I analysed the notes of all patients with one general practice who had survived at least one parasuicide, the records of all such patients in the practice being colour coded. I also analysed the notes of an equal number of controls matched for age and sex. For each patient the date of the first or only parasuicide or, for controls, the corresponding control date was found, and the number of consultations during each of the five calendar years preceding that date and during each of the years after that date (to a maximum of five years) was recorded. Also recorded were the number of prescriptions given to each patient in each of those years; the age of each patient at the time of the parasuicide; the method of parasuicide; and the times between the last consultation and the parasuicide or the control date, and between the parasuicide or the control date and the first subsequent consultation. If a patient had seen his or her general practitioner in the month preceding the parasuicide the nature of the last consultation before the parasuicide was recorded; consultations about family planning, vaccinations, and repeat prescriptions were excluded.

For the purposes of the study parasuicide was said to have occurred if there was any record of self poisoning (defined as deliberate ingestion of more than the prescribed amount of medical substances or ingestion of substances never intended for human consumption, irrespective of whether harm was intended) or of deliberate self harm irrespective of the apparent purpose of the act. Some information, such as marital state, social class, and changes in the patient's social, economic, or personal circumstances, was not always available, so no attempt was made to analyse any immediate precipitating factors for each suicide attempt.

Statistical analysis was with the paired *t* test, Maxwell's extension of the McNemar test, and the Mann-Whitney U test.

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Results

Of the practice population of about 7000, 50 patients were recorded as having survived parasuicide, giving a prevalence of 0.71%. These 50

comprised 32 female patients (average age 33.9 years; range 14-66) and 18 male patients (average age 31.3 years; range 17-54) ($t=2.12$, $df=2$, $p<0.05$). The events had occurred, on average, 7.62 years previously (range 0.3-21.0 years). Thirty six patients had taken an overdose of an analgesic obtained over the counter, 16 an overdose of benzodiazepines, nine an overdose of tricyclic antidepressants, and three an overdose of Co-proxamol, and six had used other methods (20 patients had used more than one method). Seventeen female patients and seven male patients had taken an overdose of a drug that had been newly prescribed in the month preceding the parasuicide.

Table I shows the times between the parasuicide or the control date and the last consultation before it and the first consultation after it. The mean intervals between the last consultation and the parasuicide or the control date were 13 and 61 days, respectively (median difference 38, $p<0.05$).

TABLE I—Time from last consultation and parasuicide or control date and between parasuicide or control date and first subsequent consultation. (Values are numbers of patients)

	<1 Week	1 Week to 1 month	1 Month to 1 year	>1 Year
<i>Between last consultation and parasuicide/control date</i>				
Parasuicide group	17	18	11	4
Control group	1	9	19	21
<i>Between parasuicide/control date and first consultation</i>				
Parasuicide group	19	15	14	2
Control group	1	6	18	25

Overall, patients in the parasuicide group consulted more frequently than the controls (median difference four consultations/patient/year), and the average numbers of consultations per patient were 4.18 and 1.29 a year, respectively ($p<0.02$). Five years before the parasuicide or the control date the number of consultations was 3.56 a year in the parasuicide group and 1.37 a year in the controls ($p<0.025$); in the year preceding the parasuicide or the control date these rates were 9.31 and 1.94, respectively ($p<0.05$), and they had fallen five years later to 3.52 and 1.78 respectively ($p<0.025$) (table II).

TABLE II—Average number of consultations, and of prescriptions per consultation, per patient per year in the five years before and after parasuicide or control date

	No of years before and after									
	-5	-4	-3	-2	-1 to 0	0 to +1	+2	+3	+4	+5
<i>No of consultations/patient/year</i>										
Parasuicide group	3.56	4.16	4.88	6.22	9.31	6.31	5.26	3.35	3.37	3.52
Control group	1.37	1.50	1.56	1.72	1.94	1.67	1.50	1.47	1.70	1.78
<i>No of prescriptions/consultation/patient/year</i>										
Parasuicide group	0.51	0.47	0.55	0.56	0.54	0.53	0.51	0.70	0.59	0.59
Control group	0.51	0.52	0.50	0.61	0.63	0.70	0.51	0.66	0.59	0.42

The overall average number of prescriptions issued at each consultation per patient per year was 0.52 in the parasuicide group and 0.50 in the controls ($p>0.8$); there were no significant differences in this variable between the groups at any time (table II).

Of the 35 patients who had consulted with their general practitioner in the month before their parasuicide, 23 had been recorded as being possibly psychiatrically disturbed (that is, the general practitioner had recorded formal psychiatric or somatic symptoms and signs or an opinion to that effect); of these 23, 16 had been treated with psychotropic drugs and eight had used that drug in the suicide attempt.

Discussion

Estimates of the prevalence of parasuicide based on hospital samples may miss between one fifth and one third of patients,^{9,10} and there are probably many patients whose parasuicide goes unrecorded. The number of successful suicides cannot be assessed

from the methods used. Restricting a study to a general practice population takes no account of the population's mobility, but this practice served a fairly stable, urban population mainly of social classes III and IV. The prevalence of parasuicide in general practice is variously reported to be 1.4-3.2%,¹¹⁻¹³ and the overall prevalence in this study (0.7%) may reflect the stability of the practice population.

There is little evidence that the prevalence of parasuicide differs between urban and rural areas.¹⁴ The age and sex ratios are consistent with those in most other studies.¹⁰ The methods used in the parasuicides were similar to those noted in other studies; an overdose of the most readily available, non-prescription analgesics was the most common method. The average annual consultation rate for those in the parasuicide group (4.18) was over three times that of the controls (1.29), and the difference was more pronounced for female patients (4.99 in the parasuicide group, 1.22 in the controls) than for male patients (2.74 and 1.42, respectively). When these results were analysed by year it was evident not only that those in the parasuicide group attended much more frequently than the controls but also that the rate of attendance accelerated rapidly up to the time of the parasuicide before declining to previous values; this pattern was especially noticeable among the female patients in the parasuicide group.

In clinical practice there is overwhelming evidence that patients who commit parasuicide are seeking help for their distressing condition, and their behaviour is characterised by a prodromal phase before a stage of crisis.¹⁵ This prodromal phase can be identified by an accelerating consultation rate in a patient whose consultation rate is already high, especially if, during that acceleration stage, the patient presents with overt psychiatric symptoms. Moreover, this prodromal phase is often a lengthy one, and the parasuicide may be not just an impulsive cry for help but a climax of despair in someone who has been in difficulties for some time. Not all patients who show these high risk characteristics will commit parasuicide (physical disease is another reason for such behaviour), and identifying false positive cases and false negative cases (patients who do not show these antecedent behavioural characteristics but go on to commit parasuicide) is extremely difficult. That the pattern of

increasing attendance results in a constant number of prescriptions given per attendance should act as a further warning to an alert general practitioner, who, by monitoring attendances and prescriptions of frequent attenders, should be able to identify those at risk of parasuicide especially if a pattern of increased attendance and prescriptions culminates in overt psychiatric symptoms.

Though it might be predicted that most survivors of parasuicide would attend their general practitioner within a month after the event, in this study, interestingly, most had attended in the month preceding the event as well. Of these, most had been recognised as having overt psychiatric symptoms and had been treated. That half of those treated used that treatment in their parasuicide is a failure not of identification, merely of management; perhaps by giving more supportive treatment (and perhaps also smaller prescriptions) this proportion could be reduced. The treatment of parasuicide lies in its prevention, which in turn relies on the identification of those at risk. Parasuicide is usually the result of a personal crisis and causes

considerable distress to family and friends and disruption of working life, as well as causing considerable strain on hospital based services. This study shows that parasuicide also causes a considerable increase in the workload of general practitioners, but by recognising that increase, manifested by accelerating attendance patterns in already high attenders, general practitioners are uniquely placed to intervene, to treat, and to prevent the social, psychological, and economic disruption caused by parasuicide.

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Audit Report

Prescription writing by general practitioners

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The section on prescription writing in the *British National Formulary* advises that the dose of drug, frequency of administration, and other directions should preferably be stated in plain English without abbreviation.¹ It has been reported elsewhere that prescriptions are often written incorrectly by doctors and their receptionists.²

A group of 135 general practitioners, all concerned in medical education, were invited by letter to submit duplicate copies of their first 10 prescriptions in any one week. They were not informed of the intended method of analysis but were assured of absolute confidentiality. Any doctor inquiring about the analysis was informed of the method but then excluded from the project. Invitations were sent to the members of the Newcastle young practitioners group and the trainers and trainees of the Northumbria vocational training scheme.

Each prescribed item was categorised as an inhaler, topical preparation, or other medication and was analysed to see whether the instructions on the prescription were wholly in plain English or (partly or wholly) as Latin abbreviations. Seventy six (56%) of the 135 doctors invited submitted their 10 prescriptions for analysis (760 prescriptions for 1838 items). Of the 80 prescriptions for inhalers, 26 (33%) were in Latin, 2 (3%) were wholly in plain

English, and 52 (65%) had no instructions. Of the 204 prescriptions for topical preparations, 91 (45%) were written in Latin, 19 (9%) were wholly in plain English, and 94 (46%) had no instructions. Of the remaining 1554 prescriptions, 1171 (75%) had instructions in Latin abbreviations, 265 (17%) were wholly in plain English, and 118 (8%) had no instructions.

There was no observable difference among the trainers, trainees, and young general practitioners in the manner in which they wrote their prescriptions. Many prescriptions contained mixed English and Latin instructions—for example, once daily for one item but tds for another on the same script. Some doctors mixed English and Latin instructions for a single item—for example, once daily prn.

Thus less than half the prescriptions for inhalers and topical preparations carried any instruction, and most instructions (1288; 70%) for all items were written, at least partly, as Latin abbreviations; 264 (14%) had no instructions and only 286 (16%) were written wholly in plain English. Practice clearly does not correspond with the advice given in the *British National Formulary*. This is a matter of some concern.

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