Deliberate self-poisoning: implications for psychotropic drug prescribing in general practice

KEITH HAWTON, MA, MRC.PSYCH, DPM
Clinical Lecturer in Psychiatry, University of Oxford

EILEEN BLACKSTOCK, MRC.PSYCH, DPM
Consultant Psychiatrist, Basingstoke District Hospital

SUMMARY. Several surveys have confirmed that the majority of patients who take an overdose of drugs have seen their general practitioner within the preceding few weeks; as many as a third attend within the previous week.

We studied 130 patients who had taken an overdose and interviewed 122 of the general practitioners. We found that they had identified many interpersonal problems and had usually prescribed psychotropic drugs.

We question the wisdom of this response and suggest other ways of handling such problems in general practice.

Introduction

THE need to look for means of reducing the incidence of deliberate self-poisoning is all too clear. For some years it has been a problem of epidemic proportions (Smith, 1972) and yet is still on the increase. In Oxford the rate increased fourfold between 1962 and 1972/73 (Bancroft *et al.*, 1975) and there has been a futher increase of more than 15 per cent since 1973. The majority of overdoses involve psychotropic drugs (over 60 per cent in Oxford in 1976).

The escalation in the overdose problem has been paralleled by an increase in the prescribing of psychotropic drugs so that in 1974, for example, 21·5 million prescriptions were written for tranquillizers, more than double the figure in 1964. In an international study of tranquillizer use Balter and his colleagues (1974) found that one in seven people in the UK had taken these drugs during a one-year period and that for women aged 45 to 54 the rate was one in every four.

In this paper the overdose problem is examined in relation to psychotropic drug prescribing in general practice. What are the problems brought to general practitioners by patients who take overdoses and to what extent do they receive psychotropic drugs? How should these problems be best managed and, in particular, are there alternatives to prescribing psychotropic drugs? An attempt is made to answer these questions since it is reasonable to suppose that the overdose problem will be best tackled at the primary care level. It is hoped that examination of these questions will stimulate reappraisal of the use of psychotropic drugs on the scale that has now developed.

Method

During 1972/73 a study of attempted suicide was carried out in Oxford based largely on referrals to the general hospital (Bancroft *et al.*, 1975). This included an interview study of a representative sample of 130 patients, most of whom had taken overdoses. Patients were asked about contacts that had been made with the general practitioner and their attitudes towards him as a source of help. For 122 individuals it was possible to interview the general practitioner. This interview included questions about the nature and consequences of consultations with him, particularly the final visit made by the patient before the attempt. This study has been reported in detail elsewhere (Hawton and Blackstock, 1976).

Results

Contact with the general practitioner

Several studies have shown that the majority of patients

Table 1. Frequency of relationship difficulties reported by general practitioners.

Relationship difficulty	*Men* (n = 29)	*Women* (n = 85)	*Total* (n = 114)
Marital	12 *(41)*	38 *(45)*	50 *(44)*
Extramarital	5 *(17)*	6 *(7)*	11 *(10)*
Boy/girlfriend	3 *(10)*	11 *(13)*	14 *(12)*
Sexual	4 *(14)*	7 *(8)*	11 *(10)*
Children	6 *(21)*	21 *(25)*	27 *(24)*
Family—other	5 *(17)*	15 *(18)*	20 *(18)*

who make suicide attempts or who kill themselves have contacted their general practitioners shortly beforehand. In the Oxford study 63 per cent had seen their doctors in the month before an attempt and 36 per cent in the preceding week. Similar findings were reported for attempters by Davison (1975) and for completed suicides by Barraclough and his colleages (1974). In the Oxford study at least 45 per cent of patients had contacted their general practitioners six or more times in the year before making an attempt. Proportionately fewer of the 16 to 25-year-old patients had been in recent contact with their general practitioners, which accords with the finding that at least half this group who take overdoses use non-prescribed drugs (Morgan *et al.*, 1975).

General practitioner

Almost 50 per cent of patients in the Oxford study had thought of contacting their general practitioner for help with their problems. Of those who had not consulted him some felt that he might have been too busy or might have disapproved of their problems.

Problems presented by the patients

Many patients presented with minor affective disturbances such as anxiety or depression, but these were commonly associated with psychosocial difficulties. According to the general practitioners, 63 per cent of patients had presented in the preceding year with some form of psychiatric disturbance. However, the general practitioners also reported whether they felt the patients had relationship difficulties at the time of the attempt. Their answers are analysed in Table 1.

A disturbance in a key relationship was recognized in 60 per cent of patients and in only 17 per cent was this ruled out. Half the patients reported significant rows within one week of the attempt and almost three quarters of married people were experiencing chronic marriage difficulties. Non-relationship difficulties identified by the general practitioners are shown in Table 2.

It is likely that the mood disturbances detected by the general practitioners are secondary to the psychosocial problems. Of course we do not know how many people have such difficulties and do not go to see their general practitioners, or how many see their general practitioners and do not take overdoses.

Table 2. Frequency of difficulties other than in relationships reported by general practitioners.

Problem	*Men* (n = 29)	*Women* (n = 85)	*Total* (n = 114)
Health (self)	11 *(38)*	25 *(29)*	36 *(32)*
Work (self)	12 *(41)*	9 *(11)*	21 *(18)*
Family health	3 *(10)*	16 *(19)*	19 *(17)*
Financial	8 *(28)*	11 *(13)*	19 *(17)*
Accommodation	4 *(14)*	12 *(14)*	16 *(14)*
Legal	1 *(3)*	6 *(7)*	7 *(6)*
Work (spouse)	1 *(3)*	5 *(6)*	6 *(5)*
Bereavement	1 *(3)*	3 *(4)*	4 *(4)*
Other	1 *(3)*	11 *(13)*	12 *(11)*

Use of psychotropic drugs

Sixty per cent of patients in the Oxford study were prescribed psychotropic drugs by their general practitioner within three months of their taking an overdose (Table 3). Eighty-seven per cent of patients who presented with psychiatric disturbance in the year before an attempt received psychotropic drugs in the three months before the act. At least 80 per cent of these patients used the same class of drug in the overdose as had been prescribed.

It is noteworthy that of 34 patients who received tranquillizers or sedatives at the most recent visit within three months of the attempt, 28 (82 per cent) received them within the week beforehand. The suggestion that tranquillizers might release aggression (*British Medical Journal*, 1975) poses the question of whether they could lower the threshold to self-aggressive behaviour. Of those prescribed antidepressants at their most recent visit, half had received the prescription within the previous week.

We question how far the use of psychotropic drugs is justified in view of the clear evidence of interpersonal problems. It depends on which is primary, the mood change or the interpersonal problem, but our impression has been that usually it is the latter. This suggests the possibility that other methods, such as counselling, are preferable.

Discussion

Minor affective disorders in general practice are very common. Shepherd and his colleagues (1966) found an incidence of 14 per cent in patients consulting their doctors. How can we deal with this vast amount of psychiatric morbidity? At present, psychotropic drugs are being used in most cases. Shepherd (1973) remarked: "it is evident how much our practitioner

Table 3. Psychotropic drugs prescribed within three months of suicide attempt.

Nature of drugs	Men (n = 32)	Women (n = 74)	Total (n = 106)
Tranquillizer/ sedative	13 (41)	36 (49)	49 (46)
Antidepressant	6 (19)	22 (30)	28 (26)
Barbiturate	3 (9)	3 (4)	6 (6)
Major tranquillizer	2 (6)	3 (4)	5 (5)
Any	17 (53)	47 (64)	64 (60)

relied on drugs even though they were clearly aware of the role of psychological and social factors in the presenting conditions. While a substantial number of patients presented somatic symptoms, for which a somatic form of treatment might have been regarded as understandable, this would not account for more than a small part of the whole picture".

We do not know to what extent the massive use of psychotropic drugs results in alleviating symptoms, but we should note Johnson's (1973) finding that 68 per cent of patients taking antidepressants in general practice stopped taking them of their own accord within a month of their being prescribed.

Let us examine the potential effects of prescribing these drugs to someone with psychosocial difficulties. First, it may be seen by the individual as implying that his problems are due to 'illness' and therefore not surmountable by his own efforts. Secondly, it may indicate to the patient that the doctor has prematurely terminated his assessment of the problem, thereby increasing his sense of helplessness and discouraging further discussion with the doctor. Finally, it encourages the notion of taking tablets to deal with stress and it provides a means of taking an overdose. Patients have been known to report that the idea of taking an overdose had not crystallized in their minds until they received a prescription.

Although most of these suggestions are not proven, it seems appropriate to scrutinize prescribing habits and make efforts to change them:

1. Psychotropic drugs should be prescribed only where there are definite indications: antidepressants in therapeutic doses when there is clear evidence of underlying depressive illness; tranquillizers for short periods to help patients through crises where levels of anxiety are such that their coping ability is grossly impaired; and non-barbiturate hypnotics for short periods where insomnia, secondary to stress, is undermining an individual's resources, such as during a severe grief reaction. All these are situations where psychotropic drugs may be justified, but even then they should be prescribed with care. Automatic represcribing, found to be so common for psychoactive drugs by Freed (1976), should be avoided if at all possible.

2. Prescribing of psychotropic drugs in borderline cases should be reduced. The experience in Ipswich reported by Wells (1973) is pertinent—a 65 per cent reduction in the prescribing of barbiturates resulted in only a 35 per cent increase in prescriptions for non-barbiturate hypnotics.

Clearly reduction in prescribing is only part of the answer. We must look for alternative means of providing help.

The most obvious alternative approach is for the general practitioner to concentrate more on counselling. Lack of time is usually given as the main reason why this is not feasible. There may be an unwillingness to find the time because the doctor feels inadequately trained to carry out counselling for psychosocial problems. This leaves little choice other than a brief hearing followed by a prescription. Trethowan (1975), in highlighting some of the issues in prescribing psychotropic drugs for 'personal problems', suggests that the boom in such use of these drugs may be partly explained by the increasing expectation that doctors should be skilled in areas outside their training, thus forcing them to comply with the persuasive advertising from drug companies.

Some general practitioners see patients with problems requiring counselling at designated times during the day when they can spend a little more than the customary five minutes with them. Assessment of the situation can then be more thorough. Simple explanations may be given to both the patient and key relatives as to the origin of the patient's symptoms (Gath, 1975). Reassurance should be followed by simple commonsense suggestions as to how the patient and his relatives may go about tackling the problems. In this way one can reinforce the individual's sense of responsibility and, perhaps, his confidence in his coping ability, rather than undermining these by reaching for the prescription pad. "Patients expect to receive tablets", we are told. However, this expectation can have resulted only from doctors' behaviour, so surely the responsibility for altering this expectation must lie, in part, with the medical profession?

Some general practices have developed close links with social workers who deal with relationship and similar problems. For this to be possible there needs to be close liaison and mutual respect between general practitioners and social workers. The general practitioner may have at his finger-tips a wide knowledge of the patient's social history, and the social worker should have particular skill in helping patients with psychosocial problems. Unfortunately the collaboration of general practitioners and social workers has so far had only limited success and it has been emphasized that there is a great need for doctors and social workers to learn in a multidisciplinary way (Department of Health

and Social Security, 1976). Cooper and his colleagues (1975) have gone some way in demonstrating the effects of social workers counselling chronic neurotics in general practice.

There have been experimental attachments of psychiatric nurses to general practice (Harker *et al.*, 1976). The psychiatric nurse, in addition to having skills in helping patients with relationship difficulties, should be particularly adept at coping with patients who have psychiatric symptomatology through understanding the relationship of the symptoms to other problems. In these schemes it has been possible to arrange for the psychiatric nurse to see patients fairly rapidly, often before a crisis has developed. Some psychologists are working with general practices (McAllister and Phillip, 1975) and could provide alternatives to tranquillizers in the treatment of such symptoms as anxiety, as well as helping in the management of other psychological problems.

Psychiatrists can help general practitioners in both their psychotropic drug prescribing and counselling by developing close links with group practices and paying regular visits at which problem patients could be discussed. Lyons (1969) has reported the success of such a scheme.

Additional means of emergency counselling may be needed. Walk-in clinics have not developed on the scale found in the USA, although similar facilities are appearing here (Agulnik *et al.*, 1976). However, we do have excellent voluntary crisis services, particularly the Samaritans. If the Samaritans would extend their brief to taking in emergency referrals from general practitioners, they could play a greater role in the prevention of attempted suicide than they currently appear to do (Holding, 1974).

Research needs in this field are all too apparent and urgent. The use of psychotropic drugs, especially tranquillizers, needs careful evaluation. Alternative procedures, especially for patients at risk of self-poisoning, need exploration and testing in carefully controlled studies. Common sense suggests that the current scale of psychotropic drug prescribing is unnecessary; in a proportion of cases it is almost certainly harmful.

References

Agulnik, P., Holroyd, P. & Mandelbrote, B. (1976). *British Medical Journal,* **2,** 355-357.

Balter, M. B., Levine, J. & Manheimer, D. I. (1974). *New England Journal of Medicine,* **290,** 769-774.

Bancroft, J. H. J., Skrimshire, A. M., Reynolds, F., Simkin, S. & Smith, J. (1975). *British Journal of Preventive and Social Medicine,* **29,** 170-177.

Barraclough, B., Bunch, J., Nelson, B. & Sainsbury, P. (1974). *British Journal of Psychiatry,* **125,** 355-373.

British Medical Journal (1975). Editorial, **1,** 113-114.

Cooper, B., Harwin, B. G., Delpa, C. & Shepherd, M. (1975). *Psychological Medicine,* **5,** 372-380.

Davison, K. (1975). *Medicine,* **12,** 566-568.

Department of Health and Social Security (1976). *Health Trends,* **8,** 6.

Freed, A. (1976). *British Medical Journal,* **2,** 1232-1233.

Gath, D. (1975). *Medicine,* **10,** 432-436.

Harker, P., Leopoldt, H. & Robinson, J. R. (1976). *Journal of the Royal College of General Practitioners,* **26,** 666-671.

Hawton, K. & Blackstock, E. (1976). *Psychological Medicine,* **6,** 571-575.

Holding, T. A. (1974). *British Journal of Psychiatry,* **124,** 470-472.

Johnson, D. A. W. (1973). *British Medical Journal,* **2,** 18-20.

Lyons, H. A. (1969). *Journal of the Royal College of General Practitioners,* **18,** 125-127.

McAllister, T. A. & Phillip, A. E. (1975). *British Medical Journal,* **4,** 513-514.

Morgan, G. H., Burns-Cox, J., Pocock, H. & Pottle, S. (1975). *British Journal of Psychiatry,* **127,** 564-574.

Shepherd, M., Cooper, B., Brown, A. C. & Kalton, G. W. (1966). *Psychiatric Illness in General Practice.* London: Oxford University Press.

Shepherd, M. (1973). *Journal of the Royal College of General Practitioners,* **23,** Suppl. No. 2, 16-19.

Smith, A. J. (1972). *British Medical Journal,* **4,** 157-159.

Trethowan, W. H. (1975). *British Medical Journal,* **3,** 749-751.

Wells, F. O. (1973). *Journal of the Royal College of General Practitioners,* **23,** 164-167.

Acknowledgements

This research was funded by the Department of Health and Social Security. Thanks are due to Dr J. Bancroft and Dr D. Gath for their helpful comments.