Parasuicide and General Practice: A Pilot Study

Abstract:

General Practitioners from Cork City and its environs were sent a questionnaire regarding their experience of parasuicide in the previous twelve months. Replies were received from 133 of the 185 GPs. 189 individuals, accounting for 212 episodes of parasuicide, were seen by 78 doctors, indicating a lower level of repetition than that found in hospital-referred cases. Almost a third of doctors saw no cases, just over one fifth saw one episode and the same proportion dealt with two. A small number of general practitioners saw many cases. Regarding management, 128 (60%) were referred to Casualty, 31 of whom were also referred for psychiatric care. Thirty percent were referred directly for psychiatric care. While only fourteen were retained within general practice without referral, 40% of the GPs felt that, ideally, acts of parasuicide should be retained with more specialised advice being obtained. Furthermore, 88.1% believed that management of parasuicide should form part of an integral part of post-graduate or continued general practitioner medical training. Clearly, GPs are willing to play a more active role in the management of parasuicide.

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Introduction

One aspect of the study of parasuicide which requires further clarification is the extent of the problem presenting itself to family doctors and the proportion of cases which are not referred to either the medical or psychiatric services. This proportion depends on the structure of the health services in the country under study. Twenty percent has been suggested for England and Wales.[1] No such research-based estimate has been made in respect of Ireland. The present paper, with the full co-operation and backing of the Cork City Faculty, is the first study of parasuicide in general practice in Ireland. It aims to clarify the extent to which GPs are presented with episodes of parasuicide, the referral options used and the GPs' opinions on the desired approach to the problem.

Method

The Cork City Faculty of General Practitioners was addressed at their 1995 annual meeting and the study explained to them. A list of GPs serving Cork city and its surrounding area was obtained from the Southern Health Board. Both participants and non-participants of the General Medical Scheme were included. Some general practices covered city, suburb and country areas. All those included had some city patients.

Each general practitioner was sent a short questionnaire enquiring about the number of episodes of parasuicide and individuals seen in the previous twelve months (October 1994-September 1995), the referral and management options used, the reasons for the choices made, what they considered to be the most desirable options, and how the service might be improved.

Results

One hundred and eighty-five questionnaires were sent out and replies were received from 133 (72%). This betokens the professional interest of the family doctors in these matters. Twenty-one of the replies were partially complete. Reasons for this included retirement and a lack of records of such matters. In total, 189 individuals, accounting for 212 episodes of parasuicide, were seen by 78 doctors. This gives a person/event ratio of 0.89 which is higher than that found for hospital-referred parasuicides in Cork city in 1995.[2] This indicates a lower level of repetition among those presenting to their GP.

The proportion of GPs who were not presented with an episode of parasuicide was 30.4% Figure 1. Just over a fifth (21.4%) were presented with one episode, which is exactly the same as the proportion that dealt with two. The remaining 26.8% saw three or more cases. The distribution of individuals was obviously similar to that of episodes, though slightly different due to repetitions. One and two individuals were seen by 23.2% and 25% of the GPs, respectively, while 21.4% saw three or more individuals.

A small number of GPs saw many cases. One doctor saw ten episodes occurring in ten different individuals. Three doctors dealt with eight episodes, two dealt with seven and another two dealt with six. It is likely that there are two reasons for these doctors' experience. Either they serve areas with very high parasuicide rates or their interest and expertise in these or related areas is known to the patient population.

The management of episodes accorded with expectation (Figure 2). Most (128, 60.4%) were referred to one of the city's three casualty departments, a subset of whom (31, 14.6%) were also referred for Figure 1. The extent to which GPs were presented with parasuicide (Oct 1994-Sept 1995). psychiatric care. The proportion referred directly, and solely, for psychiatric care was split very evenly between psychiatric inpatients and psychiatric outpatients. The latter included referrals to private practitioners. Just one episode was referred to a counsellor and one to a psychologist. In each of these cases, the individual was referred to a combination of places. Fourteen (6.6%) were retained within general practice without referral either because the GP was confident that the situation had been dealt with satisfactorily within the practice, or the patient or his/her family were anxious to avoid the stigma and public

exposure of either casualty or psychiatric referral.

Given that cases of parasuicide differ in some respect, whether it be method, lethality or intention, it follows that the response may also differ. Making allowance for this, the GPs were asked their opinion as to what, in an ideal or desired health service situation, should be the general practitioner's response to an act of parasuicide. More than one option was chosen by almost one fifth of the GPs. Just over half (50.9%) chose referral to casualty, where a psychiatric review would also be made. This is somewhat lower to what one would expect given the referral practices outlined earlier (60.4% of all episodes were referred to casualty).

The proportions in favour of retaining parasuicides without referral or referring them to counselling services (3.6% in each case) are in line with what is being practised. Also, 29.1% favour direct referral to the Figure 2. GPs opinion of how they would respond to an act of parasuicide in an ideal health situation. psychiatric services which is what was done with 30% of the episodes of parasuicide. However, a very large proportion of GPs (38.2%) felt that, in an ideal health service, acts of parasuicide should be retained within the practice with more specialised advice being obtained. Linked with this and in keeping with the level of concern shown by the general practitioners for the problem of parasuicide, we found that almost nine out of ten (88.1%) believed that management of parasuicide should form an integral part of post-graduate or continued general practitioner medical training.

Discussion

There are a number of possible explanations for the lower level of repetition among those presenting to their GP in comparison to those presenting to Casualty. GPs may be presented with individuals who are less ill and thus less likely to repeat. Individuals repeating parasuicide may already be acquainted with the health services, whether they be general or psychiatric, making it more likely that they bypass their GP on their way for treatment. Furthermore, repeated acts may be of a higher lethality and therefore more likely to necessitate immediate treatment in Casualty. However, it is also possible that it is the GP's treatment which has a beneficial effect in preventing repetition. If this were the case then it would have significant implications for future plans to tackle parasuicide as a public health issue.

While only fourteen episodes of parasuicide were retained within general practice without referral, almost 40% of the GPs felt that ideally, acts of parasuicide should be retained with more specialised advice being obtained. If this were to happen in general, it would have positive cost implications for the health service as it would lessen the burden on Casualty and other departments.

The willingness of GPs to become more actively involved in the management of parasuicide is further evident by the fact that almost 90% favoured it becoming part of their post-graduate or continued training. A number of GPs felt that risk assessment was one area where there was a definite need for expertise. Others felt there was a need for better communication between the GP and the psychiatric services both with respect to follow-up as well as initial treatment. Several GPs believed that the provision of community-based psychiatric clinics would be of help. These might take the form of either a shifted outpatient model or a conjoint service within the general practice setting. These might have the added advantage of avoiding the supposed stigma of psychiatric referral.

Whatever the best way forward, it is clear that the general practitioner has a key role to play, both in identifying the extent of the parasuicide problem and more importantly, responding to its occurrence in the future. These are matters we intend to take up further in our proposed prospective study of parasuicide in general practice.

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Acknowledgements

This research work was funded by the Southern and Mid-Western Health Boards, the Dept. of Health and a Unit Grant from the Health Research Board.

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