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A survey of opinions on the management of individuals who express suicidal ideation while intoxicated with alcohol

AIMS AND METHOD

It was noted that approaches to the assessment and management of individuals intoxicated with alcohol who express suicidal ideation varied widely. This study explored what guidance is currently available and sought the opinions of 218 junior and senior psychiatrists.

RESULTS

The Royal College of Psychiatrists has no specific guidelines on this issue, but the Medical Defence Union and Scottish Central Legal Office gave opinion regarding a psychiatrist's duty of care and clinical responsibilities. This information did not reflect the opinions of the psychiatrists canvassed. There was no consensus among the 65% of clinicians who responded to the survey.

CLINICAL IMPLICATIONS

There is a need for greater clarity and guidance on the management of individuals who are intoxicated and express acute suicidal ideation. Sharing of good practice guidelines and greater integration of local and national policies is needed. It is certainly a topic worthy of inclusion in all induction days for junior psychiatrists.

A significant proportion of emergency referrals to on-call psychiatrists, particularly by the police or accident and emergency (A&E) departments is for individuals intoxicated with drugs or alcohol (Suckas & Lonnqvist, 1995). There is a generally held belief that it is difficult to assess individuals who are intoxicated because this state can temporarily mimic or obscure psychiatric symptoms. However, delay in assessment may present a special problem when an individual who is intoxicated also expresses acute suicidal ideation. It is established that ingestion of alcohol is a frequent accompaniment of suicidal behaviours; 80% of individuals who complete suicide are believed to have consumed alcohol prior to the act and a similar number of individuals who engage in deliberate self-harm are also believed to have consumed alcohol (Patel *et al*, 1972; Murphy & Wetzel, 1990). These associations clearly suggest that alcohol can play a role in exacerbating suicidal thinking or suicidal behaviours.

Undertaking an accurate mental state examination and devising an appropriate management plan can be very difficult. The usual options available are to keep the individual at an A&E department, police station or place of safety until an appropriate assessment can be undertaken. This requires the consent of the individual and a sufficient staffing level to allow regular observation of the individual. Alternatively, the person could be transferred to a psychiatric setting. The latter has obvious resource implications for already stretched mental health services. As approaches varied considerably we decided to explore what guidance was currently available to help junior psychiatrists in the appropriate assessment and management of individuals intoxicated with alcohol who express ideas of suicide.

Method

We identified several potential sources of information that might offer guidance or clarify the legal position with regards to assessment of individuals intoxicated with alcohol who also express ideas of suicide (we decided to focus on alcohol, although we anticipate that similar issues may arise if individuals are intoxicated following the use of illicit drugs). We sought guidelines from the Royal College of Psychiatrists and the opinion of the Medical Defence Union (MDU). We undertook a Medline literature search of papers on legal aspects of suicide. In addition, a lawyer undertook a study of recent digests of *Scots Law* (Law Society of Scotland, 2000), the current *Law Yearbook* for England and Scotland (Law Society, 2000) and legal textbooks. The Scottish Central Legal Office (CLO) and the CLO of England and Wales were also contacted.

A questionnaire was sent to 218 psychiatrists in the west of Scotland (available from the author upon request). Those who did not respond to the initial letter were canvassed on at least one further occasion to

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maximise the response rate. The questionnaire sought opinions on three key topics: whether individuals who were intoxicated with alcohol and/or expressed ideas of suicide could be assessed; how the psychiatrist would respond to requests for such assessments; and the psychiatrist's usual management plans for these referrals. To try to help guide respondents in their descriptions of their management, they were offered two scenarios. Situation A asked how the psychiatrist would respond to a telephone referral of an individual intoxicated with alcohol who was acutely suicidal. Situation B asked how he/she would manage a patient who he/she realised was intoxicated only after the assessment had commenced. In both situations the respondents were offered a number of alternative management approaches, as well as another category where they could describe their own approach if it did not fit with the options provided. Statistically, differences in the answers to the questions for the whole group and between psychiatrists at different career grades were assessed using χ^2 tests and Wilcoxon rank order correlations.

Results

The Royal College of Psychiatrists has no specific guidelines on the issue. The Medline search revealed many interesting articles on the legal aspects of suicide and the role of alcohol intake in precipitating and predicting self-harm. However, no papers tackled specifically the subject of the assessment or management of intoxicated patients who are acutely suicidal. The search of case law and legal textbooks also failed to reveal any pertinent information.

The MDU provided the following information:

> 'If you are unable to carry out an adequate assessment of suicidal risk because of the level of intoxication, you would still have a duty of care towards the patient and you should ensure that appropriate steps are taken to protect the patient until an adequate assessment can be carried out and what might be appropriate would clearly depend on the individual circumstances of the case.
> In order to defend any claim for medical negligence, you would need to be able to demonstrate that you are acting in accordance with accepted medical practice. You would need to demonstrate that it was accepted practice amongst a body of psychiatrists not to assess patients while intoxicated. It does not matter that there may be more than one opinion in this context.' (MDU, 2000)

The CLO for England and Wales did not respond, but the Scottish CLO has stated:

> 'It is the responsibility of the clinician in whose care the patient is to arrange appropriate observation. However, a psychiatrist who does not agree to assess a patient must have good grounds for doing so.' (Scottish CLO, 2000)

Out of 218 questionnaires sent out, 141 were returned (65% response rate). The respondents comprised 60 consultants, 25 specialist registrars, 9 non-career grade staff, 46 senior house officers and 1 of unspecified clinical grade. Three consultants and 1 of non-training grade doctor specialised in the treatment of individuals with drug and alcohol problems.

With regard to general assessment, 21% of respondents stated that it was not possible to assess an individual who was intoxicated with alcohol, while 14% felt that this was feasible. The vast majority (47%) qualified their answer and suggested that limited assessment could be made. However, 58% (n=82) said they would agree to assess someone who was intoxicated who expressed suicidal ideas, 8% would only assess the individual if he/she had a history of mental health problems and 4% said they would make the assessment owing to the medico-legal implications of refusal. There were no statistically significant differences between the responses of any group of psychiatrists (junior *v.* senior, specialist *v.* generalist).

With regards to situation A (response to telephone referral of intoxicated suicidal person), 34% of psychiatrists would agree to assess the individual when they were no longer intoxicated and 29% said they would agree to assess the individual during the course of that day. A further 14% suggested that the referrer reassessed the patient when the individual was no longer intoxicated and 15% suggested that the referrer should contact the individual's general practitioner (GP) rather than the psychiatric services. Eleven individuals offered other plans or no responses to the question. There were no statistically significant differences in responses between consultants and other psychiatrists.

For situation B (management of a patient expressing suicidal ideas who the psychiatrist realised was intoxicated after commencing the assessment), 56% of individuals said that they would complete the assessment. However, 20% said that they would reassess the patient the next day, 9% said they would admit the patient and 5% suggested that they would refer the patient on to his/her GP. Again, there were no statistically significant differences in responses between consultants and psychiatrists of other training grades.

Discussion

The management of intoxicated individuals who express suicidal ideas and of the time between intoxication and sobriety has obvious resource implications for A&E departments, the policy and psychiatric services, as well as medico-legal implications for clinicians dealing with such patients.

It is disappointing that the College has no official opinion on this matter, as its guidance would clearly be helpful, particularly to junior doctors in the early stages of their psychiatry career. Different College Divisions or local hospitals and mental health services may have their own policies, but as psychiatric trainees rotate between posts it is important that all junior doctors are given guidance on this common clinical problem. A written document that reinforced any policy communicated verbally would also be helpful.

The legal advice states that the patient is the responsibility of the clinician in whose care the patient is. This would suggest that the police surgeon or the doctor at the A&E department or whoever is making the initial

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referral is responsible for the patient. However, it was notable that the Scottish CLO suggested that if a request for assessment was made (even if this is before the patient had recovered from his/her intoxicated state), the psychiatrist would then have to give an apposite reason for not making the assessment. Clarification is needed on what degree of intoxication means an assessment cannot be undertaken and whether the decision not to assess can be made without contact face to face. The information from the MDU was particularly useful. It suggested that to justify any clinical decision he/she made, a psychiatrist would have to demonstrate it was the accepted practice among a body of psychiatrists. The difficulty is that there did not appear to be a consensus among the psychiatrists surveyed as to the best way to manage such patients. In reality, when and how to assess an individual would partly depend on a balanced consideration of the degree of risk of any suicidal acts as compared with the degree of difficulty in undertaking a reliable assessment because of the level of intoxication. Given that this is known, it seems important that this is clearly recorded in a widely available document. Otherwise a psychiatrist may find his/her clinical judgement called into question because of an apparent lack of a consensus in clinical opinion.

In conclusion, there is no relevant College policy and no previous cases in law on the management of the acutely intoxicated suicidal patient. The medico-legal advice is useful, but the results of the questionnaire survey demonstrate different bodies of opinion within psychiatry. Clearly it is difficult for doctors, who are often junior, to balance the aforementioned issues when managing such patients in emergency settings. We hope that this survey will highlight this problem and encourage sharing of good practice guidelines. It is certainly a topic worthy of inclusion in all induction days for junior psychiatrists.

Declaration of interest

None.

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Intensive day programme treatment for severe anorexia nervosa – the Leicester experience

AIMS AND METHOD

To look at whether the opening of a day programme for the intensive care of people with severe anorexia nervosa in Leicester had the expected impact on admission rates, length of stay, cost of treatment and also simple measures of whether patients got better. Is this day programme an effective resource?

RESULTS

Since the opening of the day programme, in-patient bed days and overall costs of treatment for local patients have been reduced, and the early results in terms of weight gain and readmission rates are promising.

CLINICAL IMPLICATIONS

With many areas planning to set up eating disorder services for local patients, it is important to consider which are the best resources to invest in. The experience of a well-established specialist service in Leicester has shown that a day programme can be an enriching and cost-effective way to treat patients with anorexia nervosa, but that it does not replace the need for the availability of in-patient beds.

In 1997 the Leicestershire Eating Disorder Service opened a day programme for the treatment of patients with severe low-weight anorexia nervosa. This paper evaluates whether this has improved the service we offer to this group of patients and whether the venture has been cost-effective.

Piran *et al* (1989) report their outcome from the establishment of intensive out-patient programmes instituted in order to reduce the length of in-patient stay, and suggest that a day hospital programme can provide equally effective treatment of eating disorders when compared with in-patient treatment. Gerlinghoff *et al* (1998) report the results of a day hospital treatment for patients who would otherwise require in-patient admission. There was significant improvement in eating disorder symptomatology in patients with anorexia, comparable with that reported after in-patient treatment.

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