

EVALUATING THE GRAYLINGWELL HOSPITAL
COMMUNITY PSYCHIATRIC SERVICE
IN CHICHESTER
SUICIDE AND COMMUNITY CARE

PETER SAINSBURY
D. WALK
AND
JACQUELINE GRAD

An evaluation of any service which fosters extramural care of the mentally ill should include an assessment of its effects on the incidence of suicide. Critics of community care often refer to the increased risk of suicide it might be expected to incur. We have looked at this problem from four different aspects:

1. The "one-in-three" sample of patients referred to the Chichester service (271 patients) and Salisbury service (139 patients) were followed up for two years. All deaths and their causes were recorded. There were only three suicides, two in Chichester and one in Salisbury. The suicide rate for the first year of follow-up was 3.7 per 1,000 in Chichester and 7.2 in Salisbury; and the rates for the two-year period were 7.4 and 7.2, respectively.

2. These numbers were too small to provide reliable rates. We were, therefore, indebted to our colleague, Dr. D. Walk of the Maudsley Hospital, who tackled the problem by comparing the suicide rate in patients in the Chichester district during a five-year period (1952-1956), before the introduction of the community service, and during a similar period (1959-1963), after the service had started. He undertook a census of patients known to the hospital and its services at the midpoint of these two quinquennia (the years 1954 and 1961). The coroner's records of the Chichester district for the 10 years in question were then searched to find whether any suicides had been seen by a psychiatrist

from Graylingwell Hospital *in the year preceding* their deaths. When the suicides had been identified from the coroner's records, our hospital records were also searched in case any contact with the psychiatric services had been omitted in the coroner's account. The annual suicide rate per 1,000 patients for the five years preceding the service was 2.41, and for the five years following its introduction it was 1.67. (These figures are provisional only.) The difference is not significant but the findings so far certainly give no grounds for supposing that the risk of suicide has increased in patients treated in the community service.

The suicide rate of inpatients for 1,000 patients resident in hospital was 2.0 in both periods. It is worth remarking that during the earlier period the more liberal hospital regimen, open doors, and so on, had not been fully realized. Half the suicides were "on leave" in both periods.

3. The suicide rate of the general population in the Chichester service district during the same two periods was also calculated. It had not changed appreciably: The annual rate was 13.0 per 100,000 population aged 15 and over for the period 1952-1956, and 13.7 during 1959-1963. These figures provide no evidence for supposing that our policies are associated with an increased incidence of suicide in the community.

4. Finally, Dr. Walk estimated the proportion of suicides known to the hospital and its services in the two five-year periods. They did not differ: about 20 per cent of suicides (residents in the Chichester district) had seen a psychiatrist in the year preceding death in both periods. The community service is not, therefore, seeing a higher proportion of those who will commit suicide within one year.

In suicides over 65, however, four out of nine were known to the psychiatric services in 1952-1956, but none out of 12 were known in 1959-1963. So there was a significant decrease in the number of aged suicides who had been in contact with a psychiatrist following the introduction of the community service. This result is consistent with our other findings which suggest the community service is beginning to make an impact on geriatric mental illness in the area.

PREVIOUS ATTEMPTS AT SUICIDE

The only facts at present available to us on attempted suicides in the community service are from two items in the research schedule which was completed for all referrals to the community and control

services. These asked whether the patient had previously attempted suicide and whether he was currently assessed as suicidal.

A previous attempted suicide was recorded in 8.6 per cent of referrals in Chichester, but in only 3.8 per cent of those in Salisbury (the rates were 58.2 per 100,000 aged 15 and over, and 21.6, respectively). The sources of referrals in Chichester—the family doctor and general hospitals—may, therefore, very well be attaching more importance to this event in the patient's history. The community care psychiatrists certainly seem to be doing so, because we found they were admitting a higher proportion of these cases than of all referrals (30 per cent compared with 22 per cent), whereas in Salisbury less than the usual proportion of all referrals was admitted (50 per cent vs 57 per cent).

Lastly, 60 per cent of patients marked on the schedule as "suicidal" on referral were admitted to Chichester, which is nearly the same proportion as was admitted in Salisbury (68 per cent).

CONCLUSIONS

When the period in which patients were admitted to hospital informally—the wards were open and a "revolving-door" policy obtained—was compared with an earlier period in which these innovations had not been introduced, the suicide rate in the resident patients was unchanged.

Similarly, we have found no evidence that the introduction of a community care service has been accompanied by either an increase in the suicide rate of the catchment area, or an increase in the rate of suicide in patients known to the service psychiatrists. We predicted that if a community service were successful in preventing suicide there would be a decrease in the proportion of suicides in the catchment area who are known to services. Some support for the hypothesis was obtained in the geriatric population: A significant decrease was found, but the numbers were small.