British prisons where 40% of the inmates have serious drinking problems. One would also have to compare very unfavourably our overcrowded prisons and Mr Douglas Hurd's hope that the practice of 'slopping out' may cease in three years' time, with the situation in the prisons of Lower Saxony. Here, although the number of prisoners has been reduced this year from 6,041 to 5,072, the number of cells has increased from 5,887 to 6,093, the extra cells being used for recreation, hobbies and visits (Remmers, 1989). Most of the cells have their own toilets. Indeed many of our patients claim they would rather be in gaol than in hospital, as they have found the former more comfortable. I, on the other hand, have seldom seen such a well-appointed hospital.

In general the German system cares for its forensic patients flexibly, leniently and well. Baron von Münchhausen expected his audience to be broad-minded. Perhaps like that audience, we too could broaden our minds and consider other ways in which we could offer assistance to some of the more disadvantaged members of our society. Certainly we could improve our facilities.

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Psychiatric presentations to an accident and emergency department

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The nature, management and disposal of patients who present to casualty departments and receive psychiatric diagnoses by the assessing doctor are areas that have received scant attention by psychiatric researchers. The aim of this study was to analyse the records of such patients to see how they had been managed, in particular to document the degree of psychiatric intervention provided or offered, and to see what follow-up arrangements, if any, had been made.

The study

The hospital studied is located at the northern tip of its catchment area. It serves one of inner London's poorer boroughs and is close to a major train terminal. It has a busy casualty department, where over 50,000 patients are seen each year. There are both psychiatric in-patient and out-patient facilities on site, with two further in-patient units in the north and south of the district. There is a resident on-call psychiatric registrar, who can be called to assess patients in the casualty department outside of hours. During the hours of 9 a.m. to 5 p.m. the same on-call registrar can be requested to see urgent psychiatric referrals from the casualty department in the out-patient department.

All the casualty cards for the first six months of 1986 were scrutinised (n = 25,651). Information was recorded only on those patients who were judged by the casualty officer or the duty psychiatrist to be suffering from a psychiatric disorder. Patients with a psychiatric history who presented with a physical problem were excluded. Patients intoxicated with

TABLE I

Diagnoses and disposal of psychiatric patients identified in the casualty department. Numbers (percentages)

Diagnosis	*Numbers (%)*	*Seen by psychiatrist*	*Admitted to hospital*	*Not admitted but followed-up*	*No follow-up*
Deliberate self-harm	180 (39)	119 (66)	117 (65)	36 (20)	27 (15)
Alcohol misuse	79 (17)	15 (19)	7 (9)	20 (25)	52 (66)
Drug misuse	28 (6)	8 (29)	5 (18)	11 (39)	12 (43)
Psychosis	49 (11)	36 (73)	18 (37)	24 (49)	7 (14)
Affective disorder	48 (10)	32 (67)	16 (33)	27 (56)	5 (10)
Anxiety	38 (8)	8 (21)	0 (0)	21 (55)	17 (45)
Other	42 (9)	22 (52)	5 (12)	23 (55)	14 (33)
Totals	464 (100)	240 (52)*	168 (36)†	162 (35)‡	134 (29)

*χ-squared = 97.7 with 6 degrees of freedom, $P < 0.001$.
†χ-squared = 128.7 with 6 degrees of freedom, $P < 0.001$.
‡χ-squared = 40.3 with 6 degrees of freedom, $P < 0.001$.

alcohol but who presented with a physical complication, e.g. a head injury, were also excluded. Deliberate self-poisoning, although initially treated by the medical teams, was classified as a psychiatric problem. Deliberate self-harm patients who were admitted to the short stay ward were routinely referred to the duty psychiatrist, but those who were not admitted were referred at the discretion of the casualty officer.

A standardised pro forma was used to collect data. Information was recorded on demographic variables such as age, sex, and address; the mode of presentation; the presenting complaint; psychiatric diagnosis; treatment and immediate disposal. The study was performed retrospectively and, since many casualty cards contained limited information, detailed psychiatric symptomatology, sufficient to make standard research diagnoses, was often not available. A pilot study enabled us to place all the psychiatric presentations under one of the following headings: deliberate self-harm, alcohol misuse, drug misuse, psychosis, affective disorder, anxiety, and other (including personality disorder, amnesia, dementia, trans-sexualism and no diagnosis).

The data were entered onto a MINITAB computer programme. Statistical comparisons were made using the χ-squared test.

There were 25,651 casualty attenders during the first six months of 1986; of these 464 (1.8%) were judged to be suffering from a psychiatric disorder at the time of presentation. The mean age of this group was 34 years (standard deviation ± 14 years) and approximately half were under the age of 31. There were 257 (55%) men and 207 (45%) women. The majority of these patients either lived outside of the hospital's catchment area (227, 49%) or were of no fixed abode (68, 17%). Two hundred and twenty-one patients (48%) were brought to casualty by ambulance, while 209 (45%) walked in. Only 17 patients (4%) brought a letter of referral from their GP.

Patients presented to casualty throughout the day, but most commonly in the evenings: 131 (28%) arrived between 9 a.m. and 5 p.m.; 207 (45%) between 5 p.m. and 12 midnight; and 125 (27%) between 12 midnight and 9 a.m. The percentage presenting each day of the week did not vary greatly, about 15% per day with the exception of Sunday (10%).

Table I shows the psychiatric diagnoses given to the patients. The majority of patients were seen by a psychiatrist (240, 52%) and a further 26 (6%) were referred but did not wait to be seen. There were significant differences between diagnostic groups on their likelihood of being seen by a psychiatrist, $P < 0.001$ (Table I).

Only a small number of patients were prescribed psychotropic medication (52, 11%). Patients performing acts of deliberate self-harm, psychotic patients and those suffering from affective disorders were more likely to be admitted to hospital than patients in other diagnostic groups, $P < 0.001$ (Table I). Of those patients who were not admitted to hospital, over one-third were given an immediate, urgent or non-urgent out-patient appointment and just under one half were discharged from casualty without follow-up. Offers of follow-up related to diagnostic category and once again these differences were statistically significant, $P < 0.001$ (Table I).

Comment

Of the total number of patients presenting to this casualty department, 1.8% were considered to be suffering primarily from a psychiatric disorder. This is almost certainly an underestimate of the true prevalence of psychiatric disorder. Such disorders

may present with physical complications, e.g. haematemesis secondary to alcohol misuse; secondary to physical illness, e.g. cancer and depression; or coincidentally with physical illness. These types of presentation would tend to be missed or excluded from this study. Two other studies of London casualty departments reported similar prevalence rates for psychiatric disorder, 2.2% at Guy's Hospital (Anstee, 1972) and 2.5% at Kings College Hospital (Watson, 1969).

Whether patients who presented to our casualty department with psychiatric problems were 'true emergencies' or just 'casual attenders' (Fry, 1960) is not a question that can easily be answered by a retrospective study. However, certain indices, such as mode of arrival and immediate disposal, might give one a measure of the appropriateness of this route of presentation. Forty-five per cent of patients were brought to hospital by ambulance and 37% were admitted. If one excludes those patients who had performed an act of deliberate self-harm, for whom the notion of being an emergency is at least more tangible, 38% were brought to hospital by ambulance and 18% were admitted. A survey of another London casualty department revealed that 39% of new general referrals were neither accidents nor emergencies and 67% were self-referrals who had not previously seen their general practitioner (Davison *et al*, 1983). Clearly the open door policy of accident departments leaves them open to misuse by general and psychiatric patients alike.

From the results of this survey it is clear that the degree of intervention offered to patients with psychiatric problems is dependent on the nature of the presenting complaint. Patients who were psychotic, suffered from affective disorders or had deliberately harmed themselves were usually assessed by a psychiatrist and were often admitted to hospital or offered out-patient follow-up. That is not to say psychiatric intervention was offered to all patients with disabling, distressing or treatable conditions. Of all the diagnostic categories described, patients labelled 'alcohol misusers' received the least intervention, despite their problems having severe physical, psychological and social sequelae. It must be said that many of these patients were acutely intoxicated at the time of presentation, some were abusive and many were not requesting psychiatric help. However, one-third were either in a withdrawal state or were requesting detoxification, and one-third were under the age of 25 years, i.e. early on in their drinking careers. It has been argued that more help should be offered to alcohol misusers, even if they are intoxicated at the time of presentation (Healy, 1988).

Self-referral to specialists has been criticised (Williams, 1988) and casualty departments are places where this can easily occur (Jones & McGowan, 1989). Few of our patients were referred by a general practitioner, yet an increasing number of GP trainees undertake vocational training in psychiatry. However, the majority of our patients presented outside of normal working hours or at weekends, when a visit to the local casualty department might be considered preferrable to calling out the emergency doctor who may be an unfamiliar deputising doctor. A study at another London casualty department revealed that 12% of patients were not registered with a GP (Davison *et al*, 1983); for such patients there may be no alternative but the casualty department. But if many of our patients were not 'true emergencies' should they have been attending the casualty department at all? Again this depends on whether there is an alternative. Fully staffed psychiatric emergency clinics or community mental health centres which are open 24 hours a day are very few and even farther between. Rather than reproach patients for overusing what is an effective service we should be aiming to expand these alternatives. They should aim to be as flexible, accessible and free of stigma as casualty departments are and to undertake assessments without undue delay and have easy access to a specialist. For many patients casualty departments will continue to provide this service.

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