Brit. J. Psychiat. (1963), **109**, 488–490

The Psychiatric Casualty

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The facilities for dealing with the psychiatric patient who presents at the Casualty Department leave much to be desired.

The extent and nature of this problem is shown by the following study, in which one Junior Casualty Officer, who received 1,224 patients presenting with a new complaint over a period of three months, recorded the number of cases which he considered to be suffering from a primarily psychiatric condition. This amounted to 82 (*6·6 per cent.*), and, allowing for the fact that he was one of three Casualty Officers performing identical duties, this means that 984 such patients can be expected in the year. This is double the number of new cases referred to the Psychiatric Out-Patient clinic of this same hospital.

An understanding of the particular problems of the Psychiatric Casualty might indicate ways of dealing with the situation.

The Psychiatric Casualty and the Casualty Department attender

Casualty departments always have a large number of habitual attenders, and the pattern of *habital attendance* with new complaints is much increased in the case of the Psychiatric Casualty.

The majority of Casualty patients are "casual" and *self-referred* patients, but in the case of the Physical Casualty an appreciable proportion are referred by General Practitioners for second opinion, which is seldom the case with the Psychiatric Casualty. Despite the fact that the Casualty Department is primarily for traumatic conditions, the Psychiatric Casualty arrives *by ambulance* relatively more often than the Physical Casualty.

General observations are that the Psychiatric Casualty often *attends late at night*, will come in *repeatedly* over a period, and he is almost invariably *alone*. All these factors complicate his disposal, so that immediate admission to hospital was the only recourse for 21 of the 82 (*26 per cent.*) patients in the present series. Taking into account the previously mentioned conditions, this means no less than 252 such admissions in the year.

The Psychiatric Casualty and the Psychiatric Out-Patient

The Psychiatric Casualty also has certain group affinities with the Psychiatric Out-Patient. A similar number are, broadly speaking, "psychosomatic" in that they refer their main symptom to a part of the body and a similar number come to admission to a Psychiatric Unit.

TABLE II

	Symptom referred to part of body	Psychiatric admission needed	Male	Female
Psychiatric O/P.	33%	19%	46%	54%
Psychiatric Casualty	35%	17%	66%	34%

However, the sex ratio is now reversed, with a *male preponderance* in the Casualty group, and the Psychiatric Out-Patient has a more widespread age distribution, whereas the Psychiatric Casualty is predominantly in the group *35—45 years*.

TABLE I

	No. with previous attendance:	Male	Female	Mode of arrival: From G.P.	Casualty	By Ambulance
Physical Casualty ..	8%	59%	41%	14%	79%	7%
Psychiatric Casualty ..	32%	66%	34%	2%	77%	21%

https://doi.org/10.1192/bjp.109.461.488 Published online by Cambridge University Press

The diagnostic categories are different, with a weighting toward *personality disorders* in the Casualty group, and the fact that the latter goes to Casualty and not to his General Practitioner and Out-Patients is an expression of his immediately *urgent attitude* to his problem, and implies a certain *lack of insight.*

TABLE III

	Psychiatric Out-Patient	Psychiatric Casualty
Psychosis	36%	26%
Neurosis	48%	45%
Personality Disorder ..	4%	16%
Addiction	5%	7%
Mental Defect	2%	4%
Other or N.A.D. ..	5%	3%

Thus, the Psychiatric Casualty does not fit into the character of either the general Casualty attender or the Psychiatric Out-Patient exactly, although, as a group, he has affinities with both.

The Problems of the Psychiatric Casualty

The Casualty Officer was able to classify the Psychiatric Casualties into an easily recognized group with *overt* Psychiatric disorders (50) and a group with *latent* Psychiatric disorders (32) so that more than one visit or negative pathological investigations were necessary before diagnosis.

There was a striking similarity between the groups, in so far as male preponderance and habitual attendance was concerned, but they differed in the following ways.

Socially the overt group is biased towards the lower social classes, whereas the latent group resembles the Out-Patient clientèle. A common lodging house or no fixed abode was recorded for 30 per cent. of the overt cases and only 12 per cent. of the latent cases. Of the men in the overt group, 60 per cent. were not in work, as compared with 14 per cent. in the latent group.

Symptomatically the overt cases referred their main symptom to a part of the body in 18 per cent. of cases, whereas 63 per cent. of the latent cases had a "psychosomatic" complaint.

The latter group presented with somatic pains, or having collapsed, or with the commonly recognized hysterical conversion syndromes. The overt group comprised the attempted suicides and those complaining of frank depression, or with delusionary ideas, but there was a further large group who walked in alleging they had "collapsed", or were about to, the down and out, and the psychopaths finding life difficult.

Diagnostically the overt group was largely composed of chronic psychotics and those with severe personality disorders, whereas neurotic illness occurred more frequently in the latent group.

Prognostically the relapse rate, as judged by previous psychiatric treatment (usually as an In-Patient) showed that 48 per cent. of the overt group had had previous psychiatric treatment, as opposed to 16 per cent. of the latent group.

The Treatment of the Psychiatric Casualty

Immediate admission to a hospital was necessary for 21 of the 82 Psychiatric Casualties (*26 per cent.*). In 7 of these cases, the necessity was for immediate psychiatric admission to a Psychiatric Unit, 3 by the Mental Welfare Officer. All of these cases were from the overt group. A further 9 of the overt group and 5 of the latent group (*17 per cent.*) had to be immediately *admitted to medical beds* for the resuscitation of attempted suicide, the elucidation of doubtful somatic symptoms or because of threats of suicide or bizarre behaviour late at night, when psychiatric admission was administratively difficult. Of those cases admitted to medical beds, a third of the overt cases required ultimate transfer to Psychiatric Units, but none of the latent group required this.

Of the patients treated, whether as In-Patients or Out-Patients, and from overt and latent groups, a common feature was the *quick resolution* of presenting symptoms, and then discontinuance of treatment at the patients' behest. They soon discharge themselves from Mental Hospitals, or from Out-Patient attendance, once the immediate crisis is over, whether psychotic exacerbation or social adversity, in the overt case, or current emotional entanglement, in the latent case.

It seemed as if this type of patient, irrespective of his particular stress or mode of reaction to it, only wanted "Casualty" treatment, could only

https://doi.org/10.1192/bjp.109.461.488 Published online by Cambridge University Press

respond to such, and, in a limited way, did benefit from such.

With existing facilities in General Hospitals, brief admission for such treatment is not feasible, because Casualty beds are in urgent demand for the physically ill, and the established General Hospital units are far too small to cope with the influx.

At the Mental Hospital, this type of patient is unco-operative and unrewarding.

The provision of a small number of beds, in a separate ward but within the General Hospital, for the reception of the Psychiatric Casualty, would save much time, effort and expense, besides providing a specific treatment for a specific type of psychiatric patient.

On the basis of the present survey, the provision of 6 beds for ultra-short term admissions of up to 7 days would cover the needs of the Psychiatric Casualty.

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https://doi.org/10.1192/bjp.109.461.488 Published online by Cambridge University Press