

## Sudden death in psychiatric patients

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**Background** The present study investigated histories of prior psychiatric treatment in cases of sudden death reported to the coroner.

**Methods** A matching survey linked the register of deaths reported to the coroner with a comprehensive statewide psychiatric case register covering both in-patient and community-based services.

**Results** Sudden death was five times higher in people with histories of psychiatric contact. Suicide accounted for part of this excess mortality but deaths from natural causes and accidents were also elevated. Schizophrenic and affective disorders had similar suicide rates. Comorbid substance misuse doubled the risk of sudden death in affective and schizophrenic disorders.

**Conclusions** The rates of sudden death are sufficiently elevated to raise questions about current priorities in mental health care. There is a need both for greater attention to suicide risk, most notably among young people with schizophrenia, to the early detection of cardiovascular disorders and to the vigorous management of comorbid substance misuse.

Death rates among those who have been patients of mental health services are reported to be higher than for the general population (Farr, 1841; Ødegard, 1952; Gassner *et al.*, 1992; Berren *et al.*, 1994; Rosler *et al.*, 1995; Hansen *et al.*, 1997). Though suicide rates are raised across a wide range of mental disorders (Harris & Barraclough, 1997) this only accounts for part of the increased mortality. Premature death may also result from accident proneness, coexisting substance misuse (including smoking), financial and social deprivation, the side-effects of various medications and a greater incidence of concurrent physical illness (Sims, 1989; Corten *et al.*, 1991; Mehtonen *et al.*, 1991; Leeyu *et al.*, 1993; Holding & Barraclough, 1975).

Objective measures of the quality of psychiatric care have proved elusive. Suicide rates have been proposed as one such indicator but the use of wider notions of sudden, or premature, death have received less attention than they perhaps deserve. The present study set out to examine the relationship between sudden death and having previously received psychiatric care as the first stage in establishing the patterns of such mortality and their change with changing patterns of care delivery.

## METHOD

A matching survey was conducted that manually linked the register of deaths reported to the State Coroner of Victoria (total population 4.5 million with 3.6 million over the age of 15 years) between January and December 1995, and the database of all patients who had received care from public sector mental health services in Victoria.

The coroner has a statutory responsibility to investigate all deaths in which the death was unexpected, unnatural, violent or resulted from accident or injury. Other deaths reportable to the coroner include

deaths under anaesthesia, where the body is not identified, where the cause of death is not known and where the person died in custody. In total, 3831 cases were reported to the coroner in 1995, of which 176 cases under the age of 15 years were excluded from the investigation, together with another 23 cases in which the body was not identified. This left 3632 individuals who were then matched by full name and date of birth with the records contained in the psychiatric case register. The Victorian Psychiatric Case Register (VPCR) which was established in 1961 has been described as one of the largest databases in the world for psychiatric research (Eaton *et al.*, 1992), though it has been little exploited until recently. The contemporary register lists 135 992 individuals over the age of 15 years and contains data on all contacts with over 95% of public out-patient, community and in-patient services (Burgess *et al.*, 1992). In 1995, 31 000 (8.1 per 100 000) individuals were recorded as having had contact with the public psychiatric services, in over 70% of whom their care was entirely in the community. The register details contacts with services as well as the diagnosis or diagnoses (coded using ICD-9; World Health Organization, 1978) given by the attending psychiatrist, systematic reclassification of which has revealed good diagnostic reliability for schizophrenia though a less favourable result for non-psychotic disorders (Krupinski *et al.*, 1982). The register is employed to monitor levels of service activity with potential funding implications which provides a stimulus for maintaining full and prompt returns. The private sector, which does not report to the register, accounts for 6% of in-patient beds and provides out-patient services to a significant number of individuals, though predominantly with non-psychotic disorders.

The schizophrenia group, for the purposes of this paper, includes all ICD-9 codes 295 plus paranoid states (297). The affective disorders grouping incorporates ICD-9 codes 296, plus other codes for depressive disorders. The personality disorders category comprises all 301 codes. The alcohol and drug misuse categories include dependence and misuse as well as 291 and 292. Organic disorders incorporates 290, 293, 294 and in addition codes outside of the mental disorders section including 331. The other disorders incorporates all residual mental disorder categories. A no final diagnosis group is included constituting the 17% of cases on

# Sudden Death Syndromes In The Psychiatric Patient

**Padhraic Smyth**



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