Emergency psychiatric referrals to a university hospital in Pakistan

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The role of the accident and emergency department in the care of psychiatric patients has been long recognised. Mindham et al (1973) reported that many psychiatric patients, at their first or subsequent contact, present themselves as emergencies, and therefore a suitable service must be provided for them. It is interesting that a large number of reports describe various aspects of one particular service in London, namely the Maudsley Emergency Clinic. Several recent reports describe emergency psychiatric services in different district general hospitals in the United Kingdom. These reports are not comparable because of different study designs. One major difference is that while some are based in ‘walk-in’ clinics, others report clinics which assessed patients referred by general practitioners; some studies report referrals from casualty departments (Ball & Levi, 1988; Dunn & Fernando, 1989).

The majority of referred patients were men, and emergency psychiatric assessments were mostly considered justified (Mindham et al, 1973; Ball & Levi, 1988; Dunn & Fernando, 1989). The diagnoses were mainly of psychoses or neuroses, with psychoses being the larger group. Schizophrenia tended to be the largest diagnostic category and there were also a substantial number of alcohol related problems.

Due to the absence of epidemiological work, knowledge of psychiatric morbidity is rudimentary in Pakistan. Akhund et al (1987) surveyed three general practices in Karachi and reported a psychiatric morbidity of 12.1%, including 5.4% of anxiety-depression syndrome.

Although some teaching hospitals in Pakistan do provide emergency psychiatric assessments in their casualty departments, such a service has never been evaluated. What we know about emergency psychiatry is based on reports from the West. We therefore describe the first such service in a university teaching hospital in Pakistan.

The study

Work at the Aga Khan University Medical Centre (AKUMC), centrally located in Karachi, started in 1986. Among its various clinical services, it provides preventive and primary health care to seven squatter settlements of Karachi. The university hospital and the psychiatry service are still in the development phase. The hospital did not have a psychiatric ward until July 1990 and patients requiring in-patient psychiatric care were admitted into general medical beds. There were 19 out-patient psychiatric clinics every week with an average of 3,500 visits per annum during the study period.

Among other services offered at AKUMC is a 24 hours emergency room (ER). The ER is staffed and equipped primarily for the needs of physical emergencies. The on-call psychiatric team, comprising a resident medical officer and a consultant psychiatrist, takes referrals from the ER resident.

The aims of this study were to determine the nature of psychiatric crises which present to the emergency department of a general hospital in Pakistan and to audit the use of the psychiatric service in the ER.

The study is a retrospective case-notes survey of all the psychiatric referrals from ER between August 1986 and July 1990. The epidemiological data of the referrals, including age, sex, marital status, date and time of presenting in the ER, were documented along with the principal complaint, provisional diagnosis, management and follow-up arrangements. The diagnoses were made according to the ICD-9 criteria based on the clinical information recorded in the notes.

The statistical analyses were done on SPSS/PC+ software. The data for the male and female groups were compared for differences using the $\chi^2$ tests.

Findings

During the study period a total of 82,777 patients presented in ER, of whom 306 were referred on 390 occasions to the psychiatric service, giving a psychiatric morbidity rate of 0.5%. The majority of patients (53%) presented during working hours, 8 a.m. to 4 p.m., with only 9% presenting during midnight to 8 a.m.

The age of the patients ranged from 11 to 80 years with a mean of 30.39 years (s.d. = 13.01). Women
(63%) were relatively younger (mean age 29.17 years, 
s.d. = 12.41) than men (mean age 32.49 years, s.d. = 
13.80). The majority of both women (61%) and men 
(54%) were married.

Pain was the principal presenting complaint in 
23%, with other physical complaints in another 37%. 
Low mood, agitation, bizarre behaviour and violence 
towards self or others were the chief psychological 
complaints in 39%.

The largest diagnostic group (42%) was that of 
affective disorders. Other diagnoses were neuroses 
(22%), schizophrenia and paranoid states (8%), 
organic psychoses (5%), other psychiatric illnesses 
(16%) and no psychiatric disorder (3%). There were 
only two cases of alcohol related problems and none 
of a personality disorder.

Management in the ER resulted in discharge for 
6%, referral to other services for 11%, admission 
into a psychiatric bed for 13% and out-patient 
follow-up for 69%. Only 18% were regular in their 
follow-up; 43% never attended the follow-up clinic. 
A significant number (17%) made 84 repeat visits to 
ER after the index visit.

In all the variables women and married persons 
predominated but did not reach statistical signifi-

cent except for provisional diagnoses ($\chi^2 = 27.58$, 
d.f. = 4, $P = 0.001$) and follow-up compliance 
($\chi^2 = 10.62$, d.f. = 4, $P = 0.031$).

Comment

There was an increase of emergency psychiatric re-

ferrals over the years, which probably reflects the 
increasing awareness of the availability of services 
in AKUMC and does not necessarily suggest an 
increasing acceptance of psychiatric illness. The 
psychiatric morbidity rate of 0.5%, considerably 
smaller than comparable figures in British casualty 
departments and Karachi general practices, is an 
underestimate. The referrals were made by the ER 
resident and were influenced by his psychiatric 
knowledge – in fact more than 93% of the referrals 
were diagnosed as having a psychiatric disorder. 
However, many cases probably went unnoticed.

More than 60% of our patients presented with 
physical complaints although the majority of them 
were later diagnosed as suffering from a mood dis-

order. This supports the notion that people in 
industrially developing societies present with 
somatic rather than psychological complaints when 
diagnosed as suffering from psychiatric illnesses. The 
large number of affective disorders also suggests a 
difference in the clinical work of the emergency 
psychiatric service in AKUMC compared with the 
services reported in the literature.

The large number of married women in our sample 
also differs from the results reported in the literature. 
Marriage, instead of protecting against psychiatric 
morbidity, is a significant risk factor for women in 
Pakistani culture. Naeem (1990) mentioned low self-
esteem, early marriage, hostile in-laws and lack of a 
confiding relationship with the husband as important 
social factors associated with depression in Pakistani 
women. The absence of a comprehensive primary 
health care system may also explain why relatively 
few severe psychiatric illnesses, especially in a group 
of married women, presented in the ER. In good 
primary health care systems women of reproductive 
age contact their GPs more often than men. This 
provides an opportunity for their psychiatric prob-
lems to be noticed before reaching crisis point. Such 
care could have obviated the need for emergency 
psychiatric assessment in many of our referrals.

In conclusion, our study shows important differ-

ences to those reported in the Western literature: 
emergency psychiatric referrals presented mostly 
during the day, there was a preponderance of women 
and married persons, and affective disorders were the 
largest diagnostic group. On the other hand, the 
mean age, the low rate of those requiring in-patient 
treatment and poor compliance with out-patient 
follow-up are similar to the trends reported.

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