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A STUDY OF EMERGENCY PSYCHIATRIC REFERRALS IN A TEACHING GENERAL HOSPITAL[1]

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SUMMARY

The socio-demographic and clinical characteristics of one hundred consecutive referrals from emergency O.P.D. of a teaching general hospital were studied. The referral rate was 5.4%. The source, reason and purpose of the referrals were studied. Half of the patients had presented with somatic symptoms. Altered sensorium, suicidal attempt and excitements together constituted one third of all emergency referrals. The diagnosis of neurosis was given in half of the patients and one third of all patients were labelled as suffering from hysterical neurosis. The nature of the presenting complaints and psychiatric diagnoses were comparable to that of the other studies.

General hospital psychiatric units are handling most of the acute psychiatric emergencies like excitement and violence suicidal attempts, stupor etc. which previously were the domain of mental hospitals. Often operating as the "Semipermeable membrane of the mental health system" the psychiatric emergency services are called upon to manage the emotional turmoil of the patient and then direct the patient to long term sources of treatment (Schwartz, 1972). If communities are to be persuaded to accept even aggressive and unmanageable patients, then it is mandatory that emergency services must exist where these patients are attended to at once in crisis. The expert committee report on mental health recommended that as regards acute psychiatric emergencies a service providing for their recognition followed by prompt referral to an appropriate treatment centre should be available for 50% of population in a given area within a period of 5 years (W.H.O., 1975).,

Studies of psychiatric referrals have always been quite revealing. Such studies not only provide some idea about the prevalence of the illnesses but also focus on a number of other factors like the attitude of the medical profession and the community at large towards the discipline of psychiatry (Chatterjee, 1977).

There is a paucity of data concerning psychiatric emergency referrals in the Indian setting. Most of the available studies pertain to the routine inpatient referrals (Wig, 1973; Jindal and Hemrajani, 1980 ; Chatterjee, 1977) without considering the emergency aspect of the situation. Studies have been reported of emergency psychiatric consultations in Westrn countries (Anstee, 1972 ; Ungerleider, 1960 ; Whitley & Deniston, 1963 ; Eastwood *et al.*, 1970). Though psychiatric services are available in almost all teaching general hospitals in India little is known as to why the psychiatrist is called in emergency situations and what the magnitude of the problem

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is. The present study is carried out with the aim of throwing some light on these matters.

MATERIAL & METHOD

The study was carried out in the emergency outpatient department (O.P.D.) of the Nehru Hospital, a teaching general hospital, attached to the Postgraduate Institute of Medical Education & Research, Chandigarh, during the period July 26 to August 31st, 1981.

DESCRIPTION OF THE SERVICE

It is a 24 hour general emergency service where the patients or relatives can directly walk-in and request for treatment. The patient is first briefly evaluated by a Resident doctor (a postgraduate student in General Medicine) on duty and if in his assessment it is an emergency, the patient is registered and given a registration number. Consultation with a specialist is sought if the resident doctor feels that the services of the specialist are needed in the evaluation and management of the patient. The ultimate decision as to which patient requires prompt consultation with the specialist rests with the Resident doctor.

During the study period the main investigator (D.K.K.) was on call duty round the clock. He and the second author attended to all emergency psychiatric referrals and provided the necessary consultation and management. Most patients were asked to attend regular psychiatric O.P.D. after the acute emergency problems were taken care of.

One hundred consecutive emergency referrals were taken for the study which were seen from 26th July to 31st August, 1981 (35 days). The following particulars of all the cases were noted on a special proforma and the data was analysed.

(1) Total number of psychiatric referrals from emergency O.P.D. compared with total attendance at the emergency O.P.D. during the study period.
(2) Socio-demographic particulars such as age, sex, marital status, income and occupation.
(3) Source, reason (why) and purpose (for what) of referral.
(4) Presenting complaints.
(5) Psychiatric diagnosis according to I.C.D. 9.

OBSERVATIONS

TABLE 1. *Referral Rate*

Sample :

100 consecutive psychiatric emergency referrals from emergency referrals from emergency O.P.D. during 26-7-81 to 31-8-81 (35 days)

Total number of emergencies during the study period	1847
Psychiatric referral rate	5.4%
Number of total emergencies per day	52.8
Number of psychiatric referrals per day	2.8

TABLE 2. *Socio demographic characteristics*

Age (in yrs.)	
Below 24	—45 (4 cases less than 15 yrs.)
25-44	—43
45+	—12
Sex	
Male	—51
Female	—49
Marital status	
Married	—65
Single	—35
Income (Rs. per month)	
Below 399	—50
400-799	—29
800+	—21
Occupation	
Housewives	—46
Clerical & skilled worker	—23
Unskilled workers	—14
Students	—14
Others	—3

TABLE 3. *Source of referral* (N=100)

Sl. No.	Source	
1	Family friends or patient's attended on their own	73
2	Private practitioners (General physicians) & other hospital	25
3	Law enforcement	2

TABLE 4. *Reasons of referral (why the patients were referred by the Resident doctor)*

REASONS FOR REFERRAL

S. NO.	REASONS FOR REFERRAL	NO. OF PATIENTS N=100
1	PREDOMINANT PSYCHIATRIC SYMPTOMS	43
2.	NO PHYSICAL ILLNESS DETECTED	18
3.	OLD CASE OF PSYCHIATRIC SERVICE	15
4.	MENTAL SYMPTOMS COEXISTING WITH PHYSICAL ILLNESS	13
5.	ORGANIC ILLNESS INSUFFICIENT TO EXPLAIN SYMPTOMS	6
6.	ANY OTHER	5

TABLE 5. *Purpose of referral (for what the patients were referred)*

PURPOSE OF REFERRAL

S NO	PURPOSE OF REFERRAL	NO. OF PATIENTS (N=100)
1	PURELY FOR PSYCHIATRIC MANAGEMENT	55
2	FOR DIFFERENTIAL DIAGNOSIS AND MANAGEMENT	24
3	ASSOCIATED PSYCHIATRIC MANAGEMENT	21

TABLE 6. *Presenting complaints*

PRESENTING COMPLAINTS

S. NO	COMPLAINTS	NO. OF CASES (N=100)
1	SOMATIC SYMPTOMS	51
2.	SUICIDAL ATTEMPT	13
3.	HYSTERICAL FITS	11
4.	EXCITEMENT & VIOLENCE	10
5.	ALTERED SENSORIUM	9
6	ACUTE ANXIETY SYMPTOMS	6

TABLE 7. *Psychiatric diagnosis.*

PSYCHIATRIC DIAGNOSIS (I.C.D.9)

S. NO.	DIAGNOSIS	NO. OF CASES (N=100)
1.	NEUROSIS	51 (HYSTERIA: 34)
2.	FUNCTIONAL PSYCHOSIS	13
3.	ACUTE SITUATIONAL DISTURBANCE	8
4.	ORGANIC PSYCHOSIS	7
5.	ALCOHOLIC INTOXICATION	2
6.	OTHERS	3
7	NO PSYCHIATRIC DISORDER	13
8.	DIAGNOSIS DEFERRED	3

DISCUSSION

REFERRAL RATE

The emergency psychiatry referral rate of 5.4% of this study was comparable to Western studies in which it ranges from 2.2 to 5.6% (Anstee, 1972 ; Watson, 1969 ; Whitley and Deniston, 1963). This referral rate was higher than the inpatient referral rates reported in various studies which ranges from 1.17 to 2.49% (Shukla *et al.*, 1980 ; Wig and Shah, 1973). This shows that the psychiatrist's opinion is more often sought in emergency outpatient department than during ordinary inpatient care. The number of patients requiring psychiatric consultation everyday (two to three) was quite high.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

Patients below 24 years of age constituted 45% out of which 4 patients were under 15 and hence were child psychiatric emergencies. There were equal number of males and females (51 and 49 respectively.) Majority of patients were married. Poor (income below Rs. 399 per month) formed a significant number (50% of patients).

PURPOSE OF REFERRAL

The problem of diagnosis arose in 24 patients out of which 18, were referred because no physical illness was detected. However in 9 patients of this group there

was no psychiatric illness as well. These cases were "medically clear" and hence the psychiatrist was called for consultation. In 21 patients the psychiatrist was called for associated psychiatric management, which is an indication of increased awaerness of the physicians about psychiatry and their desire to associate psychiatrists in the general management of patients in an emergency.

Suicidal attempt (13%), excitement and violence (10%) and altered sensorium (9%) constituted 32% of the total referrals which indeed are emergencies. Other situations that can also be considered emergencies were the dramatic presentations of hysteria and acute anxiety attacks. These figures are comparable to Ungerleider's (1960) and Snaith and Jacobsen's study (1965). Fifty one patients presented with somatic symptoms and this figure is very high as compared to Anstee's study (1972), where it was 24%. In the study of Gautam (1978) the vast majority (88%) of the sample of patients presenting with somatic symptoms were neurotics. Coleman and Errera (1963) points out that physical complaints may be the individual's last way open to help before this adjustment fails entirely but they nonetheless represent a determined orderly pattern of behaviour.

In half of the patients a diagnosis of neurosis was given (Hysteria 34, Anxiety 9, Depression 8). In 13% of cases no psychiatric disorder was discernible. This is a higher figure than the Western studies (Ungerleider, 1960, Eastwood *et al.*, 1970), but is comparable to inpatient referrals in our country where it ranges from 6 to 15% (Shukla *et al.*, 1980 ; Wig and Shah, 1973).

COMMENTS

The emergency outpatient departments are always overcrowded. It becomes very difficult to maintain confidentiality. Because of lack of space and noisy surroundngs a proper interview with the patient becomes impossible. The authors recommend that at least a separate cubicle should be available for the psychiatrist in the emergency room. It was observed that relatives were highly disturbed as well. It is suggested that psychiatrist must spend some time with the relatives to answer their queries and explain adequately the plan of management. We advised all the psychiatric patients to attend the psychiatric O.P.D. the next day. Both the patient and the relatives found it reassuring to be invited for a second visit.

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