PSYCHIATRIC EMERGENCY SERVICE IN A MALAYSIAN GENERAL HOSPITAL

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SYNOPSIS

In February to March 1982 at the psychiatric emergency service of the University Hospital, Kuala Lumpur, some data on 491 patients (92% of 531 patients seen) were collected. Two-hundred and eighty-three patients had received psychiatric treatment and 65 had previously received medical treatment. Fifty-three per cent of the patients have schizophrenic disorders, 5.1% had situational reactions and 1.63% had chronic alcoholism. Of the 111 patients presented with either physical complaints or insomnia, eleven of them were admitted to the psychiatric wards. Three-hundred and eleven patients were followed-up in the psychiatric outpatient clinics. The availability of a psychiatric emergency service in a general hospital can contribute towards early psychiatric case findings and preventive intervention. It provides an opportunity for liaison and consultation with other medical colleagues in the care of patients with physical complaints and attempted suicides.

INTRODUCTION

With the opening of the Accidents and Emergency Service at the University Hospital, Kuala Lumpur in 1968, the first formalized 24-hours psychiatric emergency service became available in a Malaysian general hospital, with about forty psychiatric inpatient beds. Among the staff in the psychiatric unit, were one expatriate psychiatrist, Dr. D. Sarbadhikary, two psychiatric medical officers, Dr. Deva Dass and Dr. Woon Tai Hwang, and a visiting American clinical psychologist, the late Dr. N. Wagner. Currently, there are five psychiatrists, two clinical psychologists and three Master of Psychological Medicine candidates who are attached to the Psychological Medicine Unit as Medical Officers. All the psychiatrists and psychologists are academic staff of the University of Malaya, Faculty of Medicine - having both clinical responsibilities and teaching duties to undergraduate medical students and postgraduate psychiatric students.

There are two separate male and female wards. Each ward has 28 beds. There is also a psychiatric day care centre and a sheltered workshop for about thirty patients. A few paediatric psychiatric patients may be admitted to paediatric wards. Annually, the

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number of psychiatric outpatient visits varied from 8,310 in 1978 to 9,622 in 1982 in the 870-bedded University Hospital. The number of psychiatric referrals from the Accidents and Emergency (A & E) Unit increased from 713 in 1975 to 986 in 1979 - although the percentage remained at 2.1% of the total number of A & E patients seen in 1975 (34,152) and 1979 (48,003).

Currently, from 8.00 a.m. to 1.00 p.m., a medical officer, or an academic staff who is a psychiatrist of the Psychological Medicine Unit, takes turn to man the 'D' Clinic (meant for patients who come with no appointment and need to be seen immediately) and see patients referred by medical officers in the A & E Room. From 1.00 p.m. to 8.00 a.m., the following day, a medical officer (but occasionally when there is a shortage of medical officers, a lecturer) will be on call-duty for the psychiatric inpatient and the A & E. The medical officer may request the opinion of the psychiatrist on second call who is either a lecturer or a consultant. The Consultation Service for inpatient referrals is the responsibility of the Consultant-on-call.

METHOD

This prospective study of all the patients seen in 'D' Clinic and the Emergency Room during the period from February to March 1982 took place when the senior author was the Consultant-in-charge of the Psychological Medicine Unit and Dr. Loke was the Lecturer-in-charge of the Psychiatric Polyclinic and Emergency Service.

Recognizing the difficulty of getting the staff on duty to provide relevant information, the questionnaires were limited to one page. Where possible, we would look over the folders of patients seen on the day to complete the gathering of data.

RESULTS

A total of 531 patients were seen by the psychiatric staff on emergency duties, including those patients who came without appointments to the 'D' Clinic. Some data were collected on 491 (92%) of these patients.

About an equal number of male and female patients were seen - 240 and 243 respectively; 277 patients were Chinese, 106 Indians, 99 Malays and 9 were of other ethnic origins. Ninety-five patients were above 40 years old (of whom twenty-one were more than 54 years old) and 385 patients were below 40 years old (of whom one hundred and forty-five were less than 25 years old). Two-hundred and fifty-four (254) patients were single, 210 were married, four had divorced, six were widowed and one was cohabitating with a partner. There were 33 students, four pensioners, 115 unemployed persons, 86 housewives, 76 unskilled workers, 35 semi-skilled workers, 34 skilled workers, 34 clerical staff and 22 salesmen.

Forty-one of these patients were initially referred by general practitioners, ten were referred by other hospitals, four were brought in by policemen, nine were referred by the University of Malaya Students' Physician and one by the Social Welfare Department. Among patients seen at the 'D' Clinic, eight were referred by the medical clinic and one by the maternity ward.

Two-hundred and eighty-three patients had received previous psychiatric treatment, 36 patients had received medical treatment and 29 patients had received both psychiatric and medical treatment previously. Among the diagnoses following psychiatric evaluation, sixty nine patients also had medical diagnoses, two patients had surgical diagnoses.

The psychiatric diagnoses include the following: schizophrenia (260 patients, thus 52.95% of the total patient sample), depressive neurosis (17 patients), anxiety neuroses (16 patients), manic-depressive illness (13 patients), situational reactions (25 patients, i.e. 5.09%), alcoholism (5 patients) and others.

Table I shows the reasons for seeking emergency service and their subsequent hospitalization. Among the other reasons for seeking emergency service were: request for refil of medication (58 patients); missed appointments (23 patients); side-effects of medication (17 patients); job difficulties (4 patients); miscellaneous reasons - e.g. request for review of illness (15 patients).

TABLE I: REASONS FOR SEEKING EMERGENCY SERVICE (n = 491) AND THEIR HOSPITALIZATION (n = 104)

Reasons	No. of Patients	No. Hospitalised	Percentage of Hospitalization
Behavioural	91	51[a]	56.0
Relapse and Deterioration	30	8	26.7
Attempted Suicide	42	11[b]	26.2
Subjective Distress	93	22	23.7
Physical Complaints	59	6	10.2
Insomnia	52	5	9.6
Social Problem	7	1	14.3
Others	117	0	0.0
Total	491	104	

a - One patient was hospitalised at the Psychiatric Unit, General Hospital and another at Hospital Bahagia, Ulu Kinta.

b - Six were admitted to medical wards and one to surgical ward.

MANAGEMENT

The immediate management decision is whether to hospitalize these 491 patients seen in emergency unit. Ninety-five patients (19%) were admitted to the psychiatric wards, six patients were admitted to the medical and one to the surgical ward (1.4%) and only two patients (0.4%) were transferred immediately to the psychiatric unit at General Hospital, Kuala Lumpur - one patient because we had no available psychiatric bed at University Hospital at that particular time and another needed to be legally committed to Hospital Bahagia.

Among the 311 patients for follow-up at the Outpatients' Psychiatric Clinic, 142 patients (28.9%) were to be followed-up by the doctor on emergency duty and 169 (34.0%) were scheduled for follow-up by fellow psychiatric medical staff who had in most instances seen the patients previously. Nine patients were referred for follow-up at other hospitals. One patient was referred to the medical clinic and one was discharged with no follow-up. Most likely, one of the above dispositions would have been applicable to sixty-five patients whose disposition was not known. Recognizing the shortage of psychiatric social workers and the perceived ambiguous roles of the two clinical psychologists in our unit about psychotherapy, we are not surprised that not a single patient was referred to them from the doctors on emergency duty although seven patients presented with social problems and seventy-one of the patients who presented with subjective distress were not hospitalized.

DISCUSSION

The University Hospital was established as a teaching hospital which provides general service for both self-referred patients and those referred by the general practitioners. Only 41 of the 491 patients in our samples were referred by general practitioners, 10 by other hospitals and 9 by University of Malaya Students' Physicians. A large number of the 283 patients with previous psychiatric treatment, and 65 patients who had previous medical treatment were managed at the University Hospital. There were 98 patients who currently were followed-up by the regular psychiatric outpatient clinic but had to seek emergency psychiatric service because they had side-effects from medication (17 patients), missed their appointments (23 patients) or they had finished their medicine (58 patients). The latter was contributed by factors ranging from inadequate supply of the medicine by our outpatient dispensary, postponement of appointments by staff who were on leave to patients who were on maintenance chemotherapy but had lost their prescriptions after getting their last one month supply of medicine. In spite of the availability of four private psychiatrists and general practitioners in the community, the University Hospital, especially in outpatient clinics and emergency rooms are being used by mainly poor and middle class patients as a fairly economical alternative medical service.

Government and semi-government workers tend to use the general hospitals and the large majority of our patients do not have any national or private insurance and the concept and practice of family doctor is still new to both patients and some private practitioners in Malaysia. Thus, the phenomenon of using the general hospitals as "the poor man's family doctors" (1) is a choice exercised by the patients and their families.

In our sample, the five most common diagnoses were schizophrenia (52.95%), depressive neurosis (8.76%), anxiety neurosis (7.94%), manic-depressive illness (5.09%) and situational reaction (5.09%). Among the 491 patients, 95 patients were more than 40 years old; we have only eight alcoholic patients and eleven patients with hysterical conversion. In an emergency room of a mental health centre which was part of the St. Louis, Washington University Medical School programme in psychiatry, among 314 patients (127 of whom are more than 40 years old), there were 35 patients with a single diagnosis of alcoholism and 112 patients with two diagnoses, one of which is alcoholism (2).

We shall now discuss the following points:

(1) Definition of Psychiatric Emergency

The stereotype of the homicidal, suicidal or violent mental patients are not reflected in this study of 491 patients with psychiatric emergency. 8.55% (42 patients) had attempted suicide and only 2% (9 patients) were reported to be violent. 6.11% (30 patients) presented with either relapse or deterioration in their psychiatric illness. These plus the 18.5% (91 patients) who had various types of behavioural problems (i.e. alleged violent behaviour, abnormal behaviour, scolding others for no apparent reasons, laughing to themselves etc.) and the 18.9% (93 patients), with subjective distress of anxiety and depression, give a total of 54.1% of the patients with apparently psychiatric reasons for seeking emergency help.

Among 118 patients with physical complaints, insomnia and social problems, about 11% did have severe psychological problems that required hospitalisation.

Our data supported the view of the clinicians at the Massachusetts General Hospital, Boston that viewing acute psychiatric emergency case as "someone dangerous to himself or others" - does not come close to covering the range of cases being referred. They noted an alternative view regarding the emergency psychiatric problem as "seeing the act of coming to the hospital as a restitutive effort shaped in response to powerful, but predictable, psychosocial forces. To be sure, the effort may be primitive in its lack of insight." They also observed that "physical complaints may be the individual's last way open to help before his adjustment fails entirely." (1) Blane et al (3) suggested that the potential for early psychiatric case findings and preventive intervention was substantial for the patients that utilised the general hospitals.

(2) Management of Psychiatric Emergency

Our sample of 491 patients includes 59 patients (12%) who presented primarily with physical complaints and another 52 patients (10.6%) with insomnia as the chief complaint. Six of the former category and five of the latter were admitted to our psychiatric wards.

In this hospital, patients with attempted suicides

are seen initially by the medical officers at the Accidents and Emergency Unit before referral to the psychiatric staff on call so that emergency resuscitation measures may be instituted immediately if necessary. For seven of these patients, they were subsequently admitted to the medical and surgical ward.

Comparing the University Hospitals of Cleveland, where about 50% of a sample of 378 patients (who were referred over a period of six months from various parts of the hospital system for psychiatric consultation) were hospitalized with the Massachusetts General Hospital where 26% of a sample of 1,792 consecutive patients (seen between March and August 1965 at their psychiatric emergency service by psychiatrist-in-training and staff social workers) were hospitalised, Muller et al (4) observed that while fewer percentage of patients were hospitalised at the time of initial contact, more (53%, in contrast to 32% in Cleveland) were directed to return to their unit again for follow-up appointments pending final disposition. They believed that many of these return appointments represented a component of marginal cases that could easily be hospitalised. In our sample of 491 patients, a total of 21% were hospitalised, of which only 0.4% (2 patients) had to be admitted to another psychiatric unit in the same city. Sixty-three per cent (311 patients) of our samples were followed-up in our Unit, 142 patients were followed-up by the psychiatrist or psychiatrist-in-training who saw them initially in an emergency situation. We agreed with Muller et al (4) that lower-class, chronic patients followed through on long-range treatment programmes when such programmes were actively promoted in the emergency services.

(3) The Role of Psychiatric Emergency Service in Mental Health Service

Availability of an emergency psychiatric service enables the busy general duty medical officer on Accidents and Emergency Service (A & E) to refer patients with social problems. At the University Hospital, these patients form only about 2% of the total amount of A & E patients seen. These patients provide the media for liaison psychiatry in both the medical officers' level and consultation with senior psychiatric staff - facilitating a holistic care of the patients. The most obvious example is in the care of the patients with attempted suicide. Of the forty-two patients who were referred by the A & E Medical Officers, only four were admitted to psychiatric ward while six were admitted to medical wards and one to a surgical ward. The rest wre followed-up by the psychiatric unit. A controlled study of the effect of psychiatric intervention in attempted suicide in a sample of 204 patients seen at the casualty department of Kings' College Hospital, London indicated that psychiatric intervention was associated with a significant reduction in subsequent suicidal behaviour (5).

During the morning sessions at the general Polyclinic Reception counter at the University Hospital experienced staff nurses helped to direct the patients to the respective general medical or specialist clinics. Eight patients were referred by medical officers in the medical clinic to the Psychiatric Emergency Service.

There are currently about 35 psychiatrists in private practice, Ministry of Health and universities in Malaysia. The following are the other Malaysian public general hospitals with access to psychiatrists: Penang, Alor Star, Kuala Lumpur, Seremban, Malacca, Johore Bahru, Kota Bahru, Kuching and Kota Kinabalu. With the continuing emphasis on de-institutionalization and community-based services, the psychiatric emergency service in a general hospital should become "a chief entry point to the mental health delivery system." (6)

Blane et al (3) reviewing the emergency services in some American general hospitals, commented: "Intervention based on recognition of emotional components underlying, complicating, or accompanying physical complaints may be the initial step in preventing the development of a more serious disorder or of a chronic condition. The potential for early case-findings and preventive intervention with persons who tend to think of themselves in physical rather than psychological terms is very high in medical settings, and this pre-selection makes for a very different kind of patient population from that found in 24-hour settings that are explicitly psychiatric."

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