

Socio-demographic Characteristics and Decision-making For Patients with Psychiatric Emergencies Attending Mansourah University Casualty Hospital

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Background: It is evident that psychiatric emergency services play a crucial role in providing mental health services to the community. With the movement towards de-institutionalization, psychiatric emergency services PES became a major link between the community and mental health services. Studies conducted over the past three decades revealed that psychiatric emergency services are being used more often for various types of psychosocial problems.

Objectives: The aim of this study is to investigate the use of psychiatric emergency services in Mansoura University Casualty Hospital with special stress on socio-demographic characteristics of the individuals using such services. Also, to assess how much these factors can affect admission versus discharge decision in the psychiatric emergency room.

Methods: The studied group comprised the total number of psychiatric emergency patients attending Mansoura University Casualty Hospital during six months period (from June to November, 1996). This group was subjected to:

1. Socio-demographic study with special reference to age, sex, education, marital status, social class and the reasons for visits to the emergency room.
2. Complete psychiatric examination using the structured protocol of Mansoura University psychiatric department.
3. Psychometric studies using: a. Brief Psychiatric Rating Scale (BPRS).
b. Crisis Triage Rating Scale (CTRS). 4- Personality assessment: according to DSM IV classification. 5- Social class: according to an Egyptian classification of Fahmy and El-Sherbini.

Results: Psychiatric emergencies comprise 1.1% of the total number of emergency cases. The mean age of the studied group was 30.4 # 11.76 Male to females ratio was 1:1.3; most of them came from urban areas with significant higher percentage of married females as compared to single females and in single males as compared to married males. The largest group of the patients was unemployed and unskilled workers with the majority of them live in low socio-economic standard. Physical or verbal aggression, fear of self harm and fear of hurting others were the commonest reasons for visits among hospitalized patients. Relapse was more common among patients diagnosed with conversion disorder followed by mood disorders then schizophrenia and mental disorders due to general medical condition. Conversion disorder was the most common diagnosis among the studied patients followed by mood disorder then schizophrenia and substance use disorder. Schizophrenia was the commonest among hospitalized patients. The mean score of BPRS in hospitalized patients was 66.71 while in non hospitalized patients it was 48.08. The cut off score was 54. The

mean score of GAF in hospitalized patients was 29 - 39 V, . \while in non hospitalized patients it was 37- 48 A, . , \The cut off score was 42.11- The mean score of CTRS in hospitalized patients was 7.86 while in non hospitalized patients it was 11.14. The cut off score was 9.

(Egypt.J.Psychiat., 1998, 21 :257 -280).

INTRODUCTION

Psychiatric emergency is defined as any disturbance in thoughts, feelings or actions for which immediate therapeutic intervention is necessary. For a variety of reasons, such as the growing incidence of violence, the increased application of the role of organic mental disorders, epidemic of substance use disorders, the number of emergency patients is on rise (Kaplan et al, 1995).

Psychiatric emergencies must not just be seen as catastrophes. They invariably represent the nadir of a development, which has not been given enough attention while it arose. In contrast to a typical medical emergency situation the doctor is usually not particularly welcome by the disturbed psychiatric patient and his family. This may represent some hardship for the good doctor (Laemme, 1996).

With the movement towards deinstitutionalization, psychiatric emergency services PES became a major link between the community and mental health services. Studies conducted over the past three decades revealed that the pattern of use of psychiatric emergency services and the process of decision-making may be related to various types of psychosocial problems (Marson et al., 1988).

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(1) Socio-demographic variables

As reported by Gerson and Bassuk, (1983). The age of the patients, by itself, has not been consistently related to psychiatric emergency disorders while Tischler and Hanson, (1989) found that significantly greater proportions of patients use psychiatric emergency services as age increased. Also hospitalization rates increased with age only for patients with diagnosis of organic brain syndrome.

Most researches show that more women than men use psychiatric emergency services, while men were significantly more likely to be referred for inpatient treatment. (Errera et al., 1986). There is evidence from a variety of clinical studies that, men are more likely to be judged mentally ill than are women who display identical symptoms (Broverman et al 1986). A study done by Levitte and Hoffman (1995) revealed that, women attending casualty hospitals were younger and more likely to be divorced, to complain of anxiety or psychotic symptoms and to have diagnosis of depressive disorder or borderline personality disorder, Men were more likely to have a diagnosis of schizophrenia or antisocial personality disorder.

The cumulative evidence on the relationship between marital status and psychiatric emergencies suggests that if the patients have lost their partners through separation, divorce or death, they are more vulnerable to use such services. (Hanson and Babingian, 1989).

A study by Strakowski et al., (1995) reported that black patients were signifi-

cantly more likely to be diagnosed with schizophrenia and substance abuse than similar white patients, although less likely to be diagnosed with a personality disorder, black patients were significantly more likely to be hospitalized, particularly at a public hospital although there were no significant differences in insurance coverage or measures of suicidal or homicidal ideation.

Baxter et al., (1988) stated that in many but not all countries, discrepancies between the high rates of usage of psychiatric emergency services for urban areas and low rates for rural districts. Possible but unproven hypotheses concerning the urban - rural differences are:

- (1) That unstable individuals tend to migrate to cities.
- (2) That the stresses associated with life style are more in urban than rural areas.
- (3) That social cohesion is greater in rural than in urban areas.

Lower class patients are greatly over represented in the emergency services because such services are often their only medical resource. Lower class patients may therefore be expected to come to emergency rooms with non-emergency problems. In contrast, upper class patients more typically use private physicians and hospitals and therefore may be more likely to come to the emergency room with more severe and acute problems (Huffin et al., 1988).

(2) Decision-making

Schwartz et al., (1984) reported that, although therapists did not differ greatly in the proportion of patients they diagnosed as psychotics, they display considerable variability in the disposition decision made for their psychotic patients. The hospitalization rates ranged from 22% - 86% among differences in attitudinal or personality factors among the therapists. Stable therapist personality characteristics mediate the development of empathy in relation to the patient, and is necessary for further advances treatment approaches (Gerson and Bassuk, 1983).

Apsler et al., (1983) showed that psychiatrists hospitalize patients at higher rates than do social workers or psychologists. Also, psychiatrists hospitalize at significantly lower rates than do third, second, and particularly first-year psychiatric residents. Mendel and Rapport, (1983) reported that, staff social workers hospitalized the fewest patients (%25 of all patients evaluated) followed by staff psychiatrists (37%), residents (48%), and psychologists (50%). They explained these results as, social workers and non-physicians were more aware of family and community resources available to patients. Furthermore, the necessity of obtaining a psychiatrist's approval for admitting a patient to the hospital led nonphysicians to seek alternatives to admission.

Decision-makers who had had less than 6 months experience hospitalized a significantly larger number of patients than did the more experienced clinicians. Professionals with more than three years of experience hospitalized the fewest patients (32% of those presenting) followed by those with 1-3 year (41%), 6 month to a year (43%) and 0-6 month (49%). The authors suggested that the inexperienced clinicians choose hospitalization as a means of limiting decision-making responsibility (Streiner et al., 1987).

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Rusk et al. (1986) observed that, men who are passive and clinging or display regressed infantile behavior provoke reactions of rejection and hostility in their therapists. Also patients who are violent or suicidal have been found to provoke counter transference feelings of helplessness, aversion, and hate in their therapists. This ultimately affects the process of decision-making.

Social distance between the patient and the therapist is a covert yet powerful contributor to the emotional climate of the therapeutic interaction, as such it may influence other variables affecting dispositional decision making (Shader et al., 1989). Lower class patients are consistently under selected for psychotherapy. Also, therapist social class and the patient current social status interacted in the selection for psychotherapy; the social class distance between the therapist and the patient was inversely related to the frequency of psychotherapy recommendation Tischer & Hanson (1989).

The availability of family, peers and community supports and resources has uniformly influenced disposition. The presence of social resources lessens the likelihood of admission, sometimes dramatically; where as single patients and unemployed patients are more likely to be admitted. In fact, hospitalization could have been avoided if there had been a more supportive and protective social milieu (Gerson and Bassuk, 1983).

Most of the studies provide evidence that psychiatric emergency services play a crucial role in providing mental health services to a community. Examining the pattern of use of such services is needed to understand and manage psychiatric patients at general emergency facilities (Barsky, 1990).

The services of Mansoura Casualty Hospital, one of the Mansoura Universi-

ty achievements, extend to cover a big population area in Delta region. The services of the psychiatric emergency ward are fully operational 24 hours a day, five days personality week. The ward is staffed by psychiatric residents and nurses under the supervision of senior staffs of Psychiatry department. There has been a need to find out the different socio-demographic characteristics and factors affecting dispositional decisions in addition to describe the prevalence and pattern of use of psychiatric emergency services offered by Mansoura Casualty Hospital.

Thus, this study was conducted aiming at

1. Studying the prevalence of psychiatric emergencies in patients attending Mansoura Casualty Hospital.
2. Studying the socio-demographic characteristics of the individuals using psychiatric emergency services.
3. Assessment of clinical, demographic and situational factors affecting admission versus discharge decision in the psychiatric emergency room.

Material and Methods

The studied group comprises the total No. Of psychiatric emergency patients attending Mansoura University Casualty Hospital during six months period (from June to November 1996). This group was subjected to:

1. Socio-demographic assessment with special reference to age, sex, employment, sources of referral and reasons for visits to emergency facilities.
2. Complete psychiatric examination using the structured protocol of Mansoura University psychiatric department.
3. Psychometric studies using:
 - a. Brief Psychiatric Rating Scale BPRS Overall and Gorham, 1962).

b. Crisis Triage Rating Scale CTRS (Bengelsdorf and Emerson 1984).

4. Personality assessment: according based on DSM IV (1994) classification.

5. Social class: according to an Egyptian classification by Fahmy and El-Sherbini (1988).

Crisis Triage Rating Scale (CTRS):

CTRS was developed by Bengelsdorf and Emerson (1984) to help in rapid screening of emergency psychiatric patients who require hospital admission from those who are suitable for out patient crisis intervention treatment.

This (brief) rating scale is based on the fewest criteria that would most reliably and quickly predict the decision we might come to after more extensive examination. CTRS is composed of three main components, which are:

1. The degree of dangerousness of patient to self or others.
2. The capability and willingness of the patients family or other social support network to assist in the treatment plan.
3. The patients motivation and ability to cooperate in an out patient treatment plan.

A rating was devised to permit the assignment of a numerical score from 1 to 5 on each of three dimensions using descriptive statement as guidelines:

A. Dangerousness:

1. Expresses or hallucinates suicidal/homicidal ideas or has made serious attempts in the present illness. Unpredictably impulsiv violent.
2. Same as one but ideas or behavior are to some degree ego-dystonic or history of violent or impulsive behavior but no current signs.
3. Expresses suicidal/homicidal ideas with ambivalence or has made only inef-

fective gestures. Questionable impulsive control.

4. Some suicidal/homicidal ideation or behavior or history of the same, but clearly wishes and is able to control behavior.

5. No suicidal/homicidal ideation or behavior. No history of violent or impulsive behavior.

B. Support system:

1. No family. Friends, or others. Agencies cant provide immediate support needed.

2. Some support might be mobilized but its effectiveness will be limited.

3. Support system potentially available but significant difficulties exist in mobilizing it.

4. Interested family, friends or others but some question exists of ability or willingness to help.

5. Interested family, friends or others able and willing to provide support needed.

C. Ability to cooperate:

1. Unable to cooperate or actively refuse.

2. Shows little interest in or comprehension of efforts to be made in his behavior.

3. Passively accepts intervention maneuvers.

4. Wants to get help but is ambivalent or motivation is not strong.

5. Actively seeks outpatient treatment, willing and able to cooperate.

Scoring

A simple sum of the three scores provides the total CTRS score. Early trials of this CTRS indicated that most of those with scores of 8 or lower were referred for admission while those with 10 or higher tended to be suitable for outpatient crisis intervention treatment.

Those who were admitted to hospital were considered to be more dangerous, have less social support and scored lower on the CTRS than those who were discharged.

Disposition

Patients were either

- i. Referred to admission screening.
- ii. Accepted as crisis patient.

Although the CTRS showed high concordance with clinical judgment, preliminary application of this scale on the emergency patients went no further than the initial disposition decision.

RESULTS

A total of 36,810 emergency visits were made to Mansoura University Casualty Hospital during the six month-period of the present study. 405 psychiatric emergencies were identified. Thus the six-month prevalence rate for psychiatric emergencies were 1.1%. Out of these 405 visits, 59.9% (N = 239) were referred to out patient treatment; while 40.1% (N = 166) were hospitalized (table, 1).

Table 2 and figure 1 shows age and sex distribution of all patients with psychiatric emergencies. The ages of all patients ranged between 12-75 years (mean of 30.4 ± 11.761). The peak frequency of psychiatric emergency was in the range between 15 - 35 years, which represented 59.02% of the total number of patients. Out of the total number (405) of patients with psychiatric emergencies, 224 (55.34%) were females and 181 (44.66%) were males. There were no statistically significant differences between the male and female groups in all the age sectors.

Unmarried subjects followed by married spouses (44.44% and 43.7% respec-

tively) formed the largest groups of the patients. Significantly, unmarried males (25.68%) were more than unmarried females (18.77%), while married females (28.89%) were significantly more than married males (14.81%). Divorced, widows and separated spouses in both sexes represented 11.86% of the total patients (females were more than males in all of these groups but the differences were not statistically significant). These findings were represented in table 3 and figure 2.

N.B. Separation refers to a temporary state in which each spouse lives separately secondary to intramarital disturbances and it ends in either agreement or divorce.

Table 4 and figure 3 shows that the majority of patients were educated (74.57%) while 25.43% were illiterates. The secondary school students formed the highest ratio (32.1%), followed by University graduates (20.25%), then preparatory (11.61%) and lastly primary (10.61 %) schools. Illiterate females (19.51 %) were significantly more than males (5.92%). In the educated, Preparatory school male students were significantly more (9.14%) than female ones (2.47%) while university female students were significantly more (14.32%) than male ones (5.93%).

Table 5 reveals that 50.13% of the sample was belonging to low social classes, namely class III & IV (29.63% & 20.5% respectively), while 20.49% were belonging to class II and 29.38% to class I. Significant differences were found between male and female groups regarding social class. Females were belonging more to higher social classes (20% & 15.8% for class II & I respectively) compared to males belonging to the same classes (9.38% & 4.69% respectively). On the other hand, males were belonging more to lower social

Table 1
Emergency visits During the Six-month Study Period

Emergencies	Psychiatric Emergencies (n = 405)		Total Emergencies (n = 36810)		
	Hospitalized	Non-hospitalized	Psychiatric	Non-psychiatric	Total
Frequency : No	166	239	405	36405	36.810
Z (%)	(40.1)	(59.9)	1.1	98.9	100
* Significant	5.1 *		265 ***		

Table 2
Age Distribution in Relation to Sex in the Whole Sample

Age (years)	Male patients		Female patients		Z	Total patients	
	No	%	No	%		No	%
< 15	10	2.47	19	4.69	1.7	29	7.16
15 - 24	62	15.31	69	17.04	0.67	131	32.35
25 - 34	45	11.11	63	15.56	1.9	108	26.67
35 - 44	32	7.90	31	7.65	0.13	63	15.55
45 - 54	14	3.46	20	4.94	1.05	34	8.40
55 - 64	11	2.72	12	2.96	0.2	23	5.68
> 65	7	1.72	10	2.47	0.7	17	4.19
Total	181	44.69	224	55.31	3.02*	405	100
* Significant							

Table 3
Marital Status in the Whole Patients with Comparing Males and Females

Marital Status	Male patients		Female patients		Z	Total patients	
	No	%	No	%		No	%
Unmarried	104	25.68	76	18.77	2.34*	180	44.44
Married	60	14.81	117	28.89	4.85*	177	43.70
Divorced	6	1.48	12	2.96	1.43	18	4.44
Separated	6	1.48	9	2.22	0.78	15	3.71
Widows	5	1.24	10	2.47	1.3	15	3.71
Total	181	44.69	224	55.31	3.02*	405	100
* Significant							

Table 4
Education Status in the Whole Patients with Comparing Males and Females

Education	Male patients		Female patients		Z	Total patients	
	No	%	No	%		No	%
Illiterate	24	5.92	79	19.51	5.8*	103	25.43
Primary school	24	5.92	19	4.69	0.78	43	10.61
Prep. school	37	9.14	10	4.47	4.06*	47	11.61
Secondary school	72	17.78	58	14.32	1.34	130	32.10
University	24	5.93	58	14.32	3.96*	82	20.25
Total	181	44.69	224	55.31	3.02*	405	100
* Significant Prep: Preparatory							

Figure 1

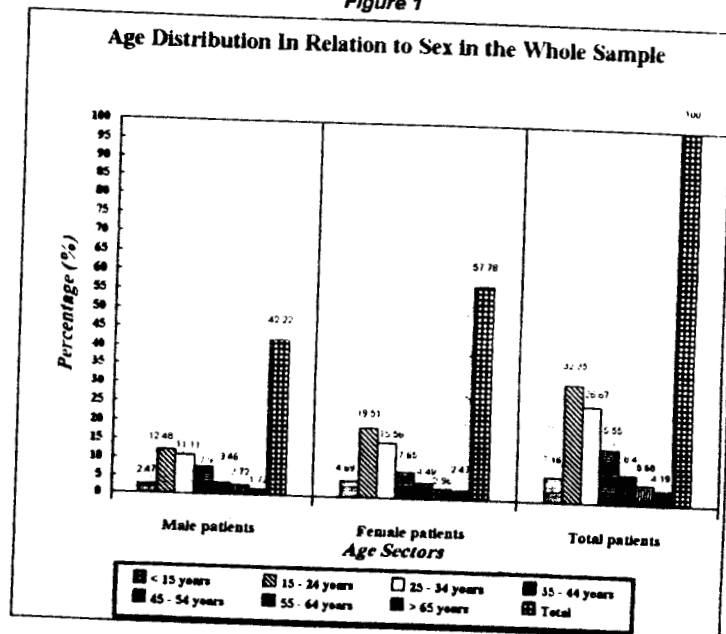
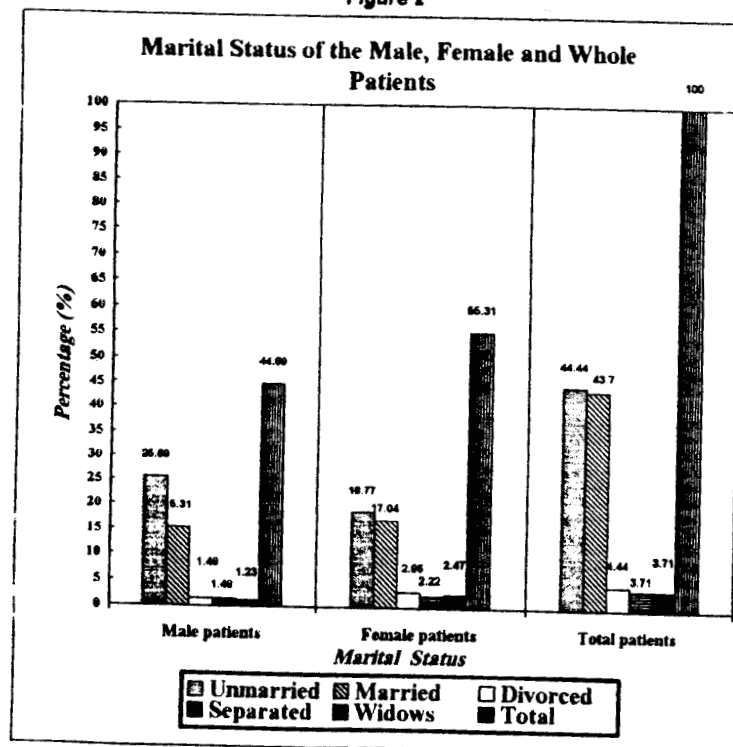


Figure 2



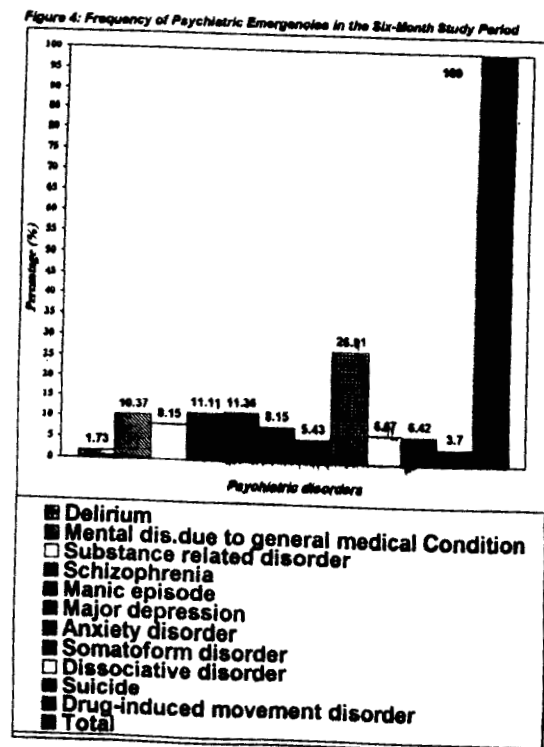
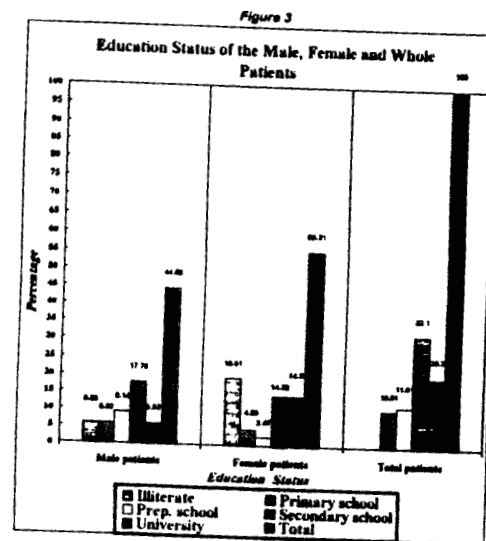


Table 5
Social Class of the Whole Patients with Comparing Males and Females

Social class	Male patients (n = 181)		Female patients (n = 224)		Z	Total patients	
	No	%	No	%		No	%
Class I	38	9.38	81	20	4.27 *	119	29.38
Class II	19	4.69	64	15.8	5.21 *	83	20.49
Class III	74	18.27	46	11.36	2.77 *	120	29.63
Class IV	50	12.35	33	8.15	1.97 *	83	20.50
Total	181	44.69	224	55.31	3.02 *	405	100

Table 6
Reasons for Referral of the Whole Patients with Comparing Males and Females

Reasons for referral	Male patients		Female patients		Z	Total patients	
	No	%	No	%		No	%
Relatives/ friends suggestions	27	6.67	80	19.76	5.5*	107	26.43
Physical / verbal aggression	37	9.14	20	4.94	2.34*	57	14.08
Dangerous to the self	18	4.44	33	8.15	2.17*	51	12.59
Dangerous to others	26	6.42	12	2.96	2.33*	38	9.38
Hospitalization	16	3.95	7	1.73	1.90	23	5.68
Found unconsciousness	7	1.72	12	2.97	1.16	19	4.69
Picked up by police (rooming)	9	2.23	6	1.47	0.70	15	3.70
Others, e.g. physician's referral	5	1.23	10	2.47	1.30	15	3.70
Total	181	44.69	224	55.31	3.02*	405	100

* Significant

Table 7
Repeated Visits of Male and Female Patients to Casualty Hospital

Relapse	Male		Female		Chi-square (X ²)	Total	
	No	%	No	%		No	%
Non-relapsers (< 2 visits)	121	29.88	82	20.25	36.6***	203	50.13
Relapsers (> 2 visits)	60	14.81	142	35.06		202	49.87
Total	181	44.69	224	55.31		405	100

* ** Highly significant

Table 8
Personality Assessment (on DSM IV) of the Whole Patients
With Comparing Males and Females

Personality clusters	Male patients		Female patients		Z	Total patients	
	No	%	No	%		No	%
Cluster "A"	29	7.16	26	6.42	0.42	55	13.58
Cluster "B"	99	24.44	103	25.44	0.32	202	49.88
Cluster "C"	16	3.95	48	11.85	4.20*	64	15.80
No personality disorder	37	9.14	47	11.60	1.20	84	20.74
Total	181	44.69	224	55.31	3.02*	405	100

* Significant

Cluster "A" Paranoid, Schizoid and schizotypal personality disorders.

Cluster "B" Antisocial, borderline, histrionic and narcissistic personality disorders.

Cluster "C" : Avoidant, dependent and obsessive personality disorders.

Table 9
Precipitating factors in the Whole Patients
With Comparing Males and Females

Precipitating factors	Male patients		Female patients		Z	Total patients	
	No	%	No	%		No	%
Marital troubles	44	10.86	25	6.18	2.4*	69	17.04
Family troubles	23	5.68	65	16.05	4.7*	88	21.73
Work troubles	28	6.91	26	6.42	0.3	54	13.33
Scholastic troubles	4	0.99	9	2.20	1.4	13	3.19
Exacerbation of the disease	11	2.72	38	9.40	4.0*	49	12.12
Impulsivity	71	17.53	61	15.06	0.95	132	32.59
Total	181	44.69	224	55.31	3.02	405	100

* Significant

Table 10
Demographic Data in Hospitalized and Non Hospitalized Patients

Demographic Data in Hospitalized and Non Hospitalized Patients								
Demographic data	Total n = 405		Hospitalized n = 155		Non-hospitalized n = 239		χ^2	P
	No	%	No	%	No	%		
Age								
Mean ± SD	30.40 11.76		29.51 9.86		31.28 13.67		0.02	>0.99 (insig)
Gender								
Male	44.66		91	54.82	90	37.66	11.673	≤0.001 sign
Female	55.34		75	45.18	149	62.34		
Residence								
Rural	35.06		89	53.61	53	22.18	42.525	≤.001 sign
Urban	64.94		77	46.39	186	77.82		
Marital status								
Unmarried	180	44.44	97	54.82	83	35.48	17.691	≤0.01 sign
Married	177	43.70	60	36.14	117	50.21		
Separated	15	3.70	7	4.22	8	3.35		
Divorced	18	4.44	6	3.61	12	5.02		
Widow	15	3.70	2	1.20	13	5.44		
Occupation								
Student	85	21	51	30.72	34	14.23	0.02	≤0.90 (insig)
Unskilled	81	20	28	16.87	53	22.18		
Skilled	51	12.59	17	10.24	34	16.32		
Professional	37	9.14	10	6.02	27	11.30		
Unemp./Hand work	128	31.60	57	34.34	71	29.71		
Retired	18	4.44	3	1.81	15	6.28		
Education								
Illiterate	103	25.43	22	13.25	81	33.89	14.322	≤0.01 sign
Primary school	43	10.62	20	12.05	23	9.62		
Prep school	47	11.60	20	12.05	27	11.3		
2nd school	130	32.1	69	41.57	64	26.78		
University	82	19.51	35	21.08	44	18.41		
Unemp: unemployed								

Unemp: unemployed

Table 11
Relation of the Grades of Severity (Based on the Total Scores of Brief Psychiatric Rating Scale "BPRS") and the Decision of Hospitalization

Severity grade (by BPRS score)	Total (n = 405)		Hospitalized (n = 166)		Non-hospitalized (n = 239)	
	No	%	No	%	No	%
Mild (1-40)	167	41.23	16	3.95	151	37.28
Moderate (41-70)	206	50.86	124	30.62	82	20.25
Severe (> 70)	32	7.90	26	6.42	6	1.48
Chi-square (X ²)	121 * * *					
*** Highly significant						

Table 12
Relation of the BPRS Cut Off Score "54" and the Decision of Hospitalization

BPRS score	Hospitalized (n = 166)		Non-hospitalized (n = 239)	
	No	%	No	%
≥ 54	153	92.17	52	21.76
< 54	13	7.83	187	78.24
Chi-square (X ²)	194 * * *			
*** Highly significant		BPRS: brief psychiatric rating scale		

Table 13
Relation of the CTRS Total Score and the Decision of Hospitalization

BPRS score	Hospitalized (n = 166)	
	No	%
Mean	7.86	11.14
± SD	2.93	2.3
Significance	194 * * *	
*** Highly significant	t = 16.77 p < 0.0001***	

Table 14
Relation of the CTRS Cut Off Score "9" and the Decision of Hospitalization

BPRS score	Hospitalized (n = 166)		Non-hospitalized (n = 239)	
	No	%	No	%
≥ 9	144	76.60	44	23.40
< 9	22	10.14	195	89.86
Chi-square (X ²)	18.39 * * *			
CTRS: Crisis Triage Rating Scale		* * * highly significant		

classes (18.27% & 12.35% for class III & IV respectively) compared to females belonging to the same classes (11.36% & 8.15% respectively).

A variety of reasons were given for visiting the casualty hospital (tables 6 and 7). For 26.42% of the visits, friends or relatives had suggested the use of emergency service, while 14.08% involved the physical and verbal aggression and 12.59% involved the fear of self-harm. Fear of hurting others represented 9.38% of all visits. A small proportion of visits (5.68%) was made to gain admission to hospital. Those who were picked up (found unconscious or rooming) constituted 8.39%. Males and females differed significantly in their reasons for referral. Females were referred more through suggestions by relatives and friends than males (19.76% & 6.67% respectively). Also, fear of hurting self was encountered more in females than males (8.15% and 4.44% respectively). On the other hand, males more than females were referred due to physical / verbal aggression (9.14% and 4.94% respectively) or due to fear of hurting others (6.42% and 2.96% respectively). Other reasons did not show significant differences between males and females. Approximately one-half of the patients (49.87%) visited the emergency room more than 2 times (Relapsers were those who had more than 2 visits). Relapsers were more encountered among the female group as compared to the male group (35.06% and 14.81% respectively).

Table 8 shows that the greatest proportion of patients had personality disorders belonging to cluster B(49.88%) followed by cluster ...C (15.80%) and lastly cluster ...A (13.58%). Cluster ...C contained significantly more females (11.85%) than males (3.95%).

Table 9 shows that impulsivity and

family troubles were the major precipitating factors for psychiatric emergencies (54.32%) followed by marital, work, Exacerbation of the disease and scholastic troubles (17.04%, 13.33%, 12.12% and 3.19% respectively). Females had significantly more precipitation by family troubles and exacerbation of disease (16.05% and 9.4% respectively) than males (5.68% and 2.72%) while males had significantly more marital troubles (10.86%) than females (6.18%).

Figure 4 presents the frequency of psychiatric emergencies in the six-month study period. 26.91% of the sample were diagnosed as somatoform disorders, followed by mood disorders (19.51%), Schizophrenia (11.11%), mental disorder due to gen. medical condition (10.37%), substance related disorders (8.14%), dissociative disorders (6.67%), suicide (6.42%), medication induced movement disorder (3.7%) and delirium (1.73%).

Table (10) compares sociodemographic data in hospitalized and non-hospitalized patients. The mean age and type of occupation did not show significant differences in either group. Regarding sex; males, in contrast to females, were significantly more hospitalized. 53.61% of hospitalized patients were from rural areas, while 77.82% of non-hospitalized patients were referred from urban areas. The largest proportion of hospitalized group was formed by the unmarried subjects followed by married spouses (54.82%, 36.14% respectively) in contrast to non-hospitalized group where the married spouses were more prevalent (50.21%). Among hospitalized group, unemployed patients had the highest ratio (34.34%) followed by unskilled and student patients (30.72%, 16.87% respectively) with no significant differences between both non-

hospitalized and hospitalized groups. Regarding education, significant difference between both groups was found. More than 70% of hospitalized patients were educated. Compared to about one third of non-hospitalized patients who were illiterates.

Tables 11 & 12 demonstrate the relationship between the BPRS (brief psychiatric rating scale) scores and rate of admission. The more severe the illness (as assessed by the BPRS), the higher the rate of hospitalization ($X^2=121$). The BPRS cut off score was found to be ... (i.e. more than or equal to 54 indicates hospitalization and less than 54 indicates that out-patient treatment would be sufficient).

Tables 13 & 14 shows the relation between the overall rate of hospitalization and the total CTRS score. The mean score for those who were hospitalized was (7.68, SD compared to 11.14 (SD) for those who were discharged. The mean score for all patients was 8.5 (SD). There was high significant difference between both groups. The CTRS cut-off score was found to be ... i.e. less than or equal ... indicates hospitalization and greater than indicates that out patient treatment would be sufficient.

DISCUSSION

Over the past two decades, psychiatric emergency services have become the prime entry point for individuals into mental health services. This is due, largely, to our continuing emphasis on deinstitutionalization and community based services. An understanding of the clinical characteristics of patients using psychiatric emergency services is important for adequate planning of such facilities (Bauer and Balter 1989).

The mobile psychiatric crisis intervention service, whose work was studied, operates 24 hours a day at a major public receiving hospital for acutely ill psychiatric patients. Requests for admission or for emergency psychiatric services are routinely referred to the crisis intervention service. A team of a psychiatrist and another mental health professional determine whether crisis intervention treatment and referral for other outpatient treatment is safe and feasible or if immediate hospitalization is required (Everson et al., 1989).

Overall, the results suggest that the nature of services that the psychiatric emergency patients received were based on structural, psychosocial and clinical considerations. Emergency facilities were more likely to offer psychiatric consultations to admit patients to a psychiatric unit and to arrange follow up appointments (Benglsdorf et al., 1993).

Of the total number of the emergency cases attending Mansoura University Casualty Hospital during the studied six months period, 1.1% were psychiatric emergencies. While Oyewumi et al., (1992) found during their study in Canadian City that psychiatric emergency visits were 2.32% of the total number of visits to emergency facilities. Also the rate of psychiatric emergencies was higher at Saskatchewan University Hospital (3.9%) and Saskatoon City Hospital (2.1%). These higher rates in contrast with our study may be attributed to the fact that:

(1) These centers have special psychiatric units (Segal et al., 1988).

(2) Peoples in our culture are less likely to seek psychiatric service for fear of stigma of being psychiatric patient.

(3) Non-psychiatric staff sees the problems of psychiatric patients as self-inflicted, non-emergency and unsuitable for immediate resolution. This view often results in negligence of psychiatric cases (Beahan et al., 1987).

Of the total number of psychiatric emergencies (405 patients), 40.1% (166 patients) were hospitalized and 59.9% (239 patients) were treated and advised to follow up. This finding was in agreement with many studies. Friedman et al., (1989), Walter and Hiram, (1995) and Kua et al., (1995).

James et al., (1991) admit 61% of psychiatric patients during their study; that is because most of them were violent and brought by police.

In a study done by Paulette et al., (1989) the rate of hospitalization was little than in our study (26%); that is because their study done at Cincinatti Hospital which had the availability of a holding area or extended evaluation unit and thus reduce hospitalization rate. However the services offered by holding areas will postpone hospitalization rather than avoiding them.

William et al., (1996) recommended the strategy of reducing hospitalization rate as they found no difference between subjects admitted to a day hospital and those admitted as inpatient on the number of outcome variables, including post discharge mental health service, re-hospitalization, and patient or family rating of their psychiatric status.

However, this system could not be adopted because many of our patients were homeless and/or came from destructive social environments that made delivery of treatment and recovery in a day hospital alone unlikely. This explanation was supported by (Klutter et al., 1992).

The mean age of our studied group was 30.4 with a range of 12 - 75 years; 84% of the patients were between 20 and 49 years. This result was consistent with the study adopted by Walter et al., (1995) and Kua et al., (1995) who found that the mean age for psychiatric emergencies was 33.8 years within the range of 17 to 82 years.

More females than males were represented in this study; male to female ratio was 1: 1.3. This finding was consistent with Binder & Nile, (1990) and Gabbard et al., (1994). Also, Goldberg & Huxley, (1980) found that psychiatric emergencies were more common in women than in men. It is also consistent with Najim & Al-Lowed, (1989) and Al Erani, (1996) who found that male to female ratio 1: 1.2.

However, it is not consistent with Okasha study in Egypt (1966), who reported that males are more (57.4%) than females (42.4%). Our results may be attributed to the fact that men are more likely to be judged mentally ill than are women who display identical symptoms.

In the present study, it was found that most of psychiatric emergencies occur in young age. The mean age was 23.6 years for suicide, 24.9 years for substance abuse, 27.6 years for panic and conversion disorders, 30.07 years for schizophrenia, and 39.9 years for manic episode. These findings were in agreement with Kreitman et al., (1990) and Gabbard et al., (1994).

Also, Blixen et al., (1994) reported that a significant portion of psychiatric and substance abuse disorders were found among the youngest old patients, while the oldest made a great number of visits to the emergency room.

Psychiatric emergencies in the elderly form a small percent of all elderly

patients treated in emergency departments. In the present study, elderly patients commonly presented by delirium, medication induced side effects and mental disorders due to general medical condition. This finding was supported by Tueth, (1994) who said that emergency behavioral syndromes in the elderly include confusion, agitation, psychosis, and behavioral regression. Causes of these syndromes in the elderly include delirium, dementia, medication-induced side effects, physical illness and depression.

In the present study, the most common psychiatric disorders among male group were substance abuse, schizophrenia and manic episode; while female group mostly diagnosed with major depression, panic disorder, conversion disorder and suicide.

Violence was more prevalent among male group than female group. This finding agreed with Levitte & Hoffman, (1995) as they revealed that women attending Casualty Hospitals were younger and more likely to be divorced, to complain of anxiety or psychotic symptoms and to have a diagnosis of depressive disorder or border line personality disorder.

On the other hand, Fawzy & Al-Atrony, (1985) found that suicide attempts were less among females than males due to the earlier age of marriage for them with subsequent protection. Also the females chances for education and work are still limited and hence they are less exposed to stress. However, the results of the present study indicated that females were brought to the psychiatric emergency room because of fear of self-hurting while males had more tendency to hurt others and to express verbal and physical aggression. This could be explained by the sciocultural factors, which allow men to reveal their emo-

tions more than the females who tend to be more submissive and dependent.

However, McNeil et al., (1988) and Newhill et al., (1995) concluded that when the patients were stratified by gender, no significant differences were found in the rates of inpatient violence among the different diagnostic groups. The observed gender differences in location in which violence took place may be related to differences in the social worlds of men and women, with men having more opportunity for public violence with strangers.

On the other hand, James et al., (1991) reported that women were more violent than men were. Women more often committed assault or battery; while men more often made threats or were a source of concern to staff. Perhaps these findings reflect the fact that women who make threats inspire less fear than men who do so. Women come to the attention of the psychiatric emergency service after they act; their talk causes less concern.

While Tanke & Yesavage, (1989) found that men were more likely than women to engage in fear inducing behavior, whereas women were over-represented in the physically assaultive group. Since the distribution of the diagnostic categories differed by gender, among men, but not women, schizophrenic and manic patients were significant. These findings were supported by our study.

In the present study, there was no significant association between the age and the decision to hospitalize. While Tischer & Hanson (1989) found that significant greater proportions of patients were hospitalized as age increased.

Regarding sex, significant tendency to hospitalize men more than women was found. That might be attributed to

the fear of labeling women and the social stigma about hospitalization for mental illness for which females are more sensitive. These results were consistent with Gerson & Bassuk, (1983), Errera et al., (1986), McNeil et al., (1988), Plauette et al., (1989) and William et al., (1996).

In the present study, 64.94% of the patients studied were coming from urban areas especially among suicidal patients. This preponderance of urban cities than rural areas coincides with the studies of Tsuang et al., (1992) and Baxter et al., (1988). This may indicate the hazards of overcrowding of urban areas with subsequent social deprivation and weak family ties. Also, the stresses associated with life style in urban areas may play a role.

No significant associations were found between residence and decision to hospitalize. This finding was consistent with McNeil et al., (1992) and William et al., (1996).

In the present study, there was a significant higher percentage of married females as compared to single females and in single males as compared to married males. This result was compatible with some western studies which indicate that marriage might be considered as a factor of stress for females and on the other hand - a protective factor for males Freeman, (1983).

Divorced, widowed and separated spouses in both sexes represent 11% of the total patients but the number of females were more than males. This might suggest that such life events have greater impact on females than on males because males can accommodate better in a male-dominated society.

Hanson & Babingian, (1989) suggested that the chance of being hospitalized is significantly greater if the pa-

tients have lost their partners through separation, divorce or death. Also, Oyewumi et al., (1992) found that 70% of hospitalized patients were single, separated, divorced or widowed. These marital problems among hospitalized patients reflect the inadaptability and maladjustment among those persons. These findings were supported by our results..

In the present study, educated subjects were found to constitute the majority of our sample. The secondary and higher school graduates form the highest ratio. Most of suicidal patients were educated. These results were in agreement with Fawzy & Al-Atrony, (1985) where they explain this result by the degree of stress evoked by education. Also, educated subjects are usually more ambitious and competitive and thus, exposed to more frustration.

No significant association was detected between the education of the patients and the decision to hospitalize. This finding was in accordance with McNeil et al., (1992) and William et al., (1996). While the majority of hospitalized patients in Friedman et al., (1989) study were poorly educated.

The largest group in the present study was unemployed and unskilled workers (51.6%), also, the majority of hospitalized patients lie in this group. This result was supported by the opinion adopted by Oyewumi et al., (1992) who found that 62.4% of psychiatric emergency patients were unemployed. Also, William et al., (1996) reported that over 96% of psychiatric emergency patients were classified either as category I (unskilled workers or unemployed, 63%) and category II (semiskilled workers, 33%).

In contrast to Freedman et al., (1989), where they found that only 11% of hospitalized patients held part time or

full time jobs, and over 60% never finish high school.

Our study also revealed a significant link between suicide, substance abuse and unemployment. This finding was consistent with Tsuang et al., (1992) and Gabbard et al., (1994).

Our study revealed that more than half of the patients were living in low socio-economic standard. Also, Oyewumi et al., (1992) suggested that more than 80% of patients seen at emergency facilities were from the two lowest socio-economic classes. These results were consistent with El-Boraie & Gomma, (1996) where they found that patients with low socio-economic standard were more liable to develop psychiatric disorders. This may be explained by the presence of emotional deprivation, lack of community cohesion, competition among siblings for limited parental resources of care and attention.

In this study, 74.43% of hospitalized patients were living in low socio-economic class. This finding was in accordance with Hollingohead & Redlich, (1989) and Shader et al., (1989) who found that lower class patients were frequently hospitalized and received less psychotherapy than upper class group. That is because lower class patients are greatly over presented in the emergency services as such services are often their only medical resource. In contrast, upper class patients more typically use private physicians and hospital and therefore may be more likely to come to the emergency room with more severe and acute problems.

In the present study, suicide, conversion, panic and dissociative disorders were precipitated mainly by marital, family and work troubles. This finding was consistent with Wenz, (1979) who reported that family quarrels as the first cause followed by marital disturbance,

educational troubles and others. While, Handerson, (1987) and Eferekya, (1989) distinguished mental illness as the major precipitating factor followed by situational factors. On the other hand, these findings provide new indications about the role of weak family ties and lack of social integrity in the causation of psychiatric emergencies.

The fact that large percentages of patients using psychiatric emergency room have histories or symptoms of life threatening behavior make the judgment of dangerousness an important aspect in decision to hospitalize (Baxter et al., 1988).

Also, in this study, impulsivity and exacerbation of the disease were the commonest precipitating factors for hospitalization. While marital, family and work troubles were the commonest among non hospitalized patients where most of them had neurotic disorders.

There was a significant association between the rate of hospitalization and the severity of illness as assessed by BSRS. The cut off score of BPRS was 54 (i.e. more than or equal 54 indicates hospitalization and less than 54 indicates that outpatient treatment is sufficient. Our result was near to that of Paulette et al., (1989) study in Cincinnati hospital. While Apsler et al., (1983) found that the mean score of BPRS in hospitalized and non hospitalized patients were 54, 40 respectively. This difference with our result might be due to the higher severity of psychiatric illness among our studied patients.

The mean score of CTRS in our hospitalized patients was 7.8 while in non hospitalized patients, it was 11.14. The cut off score of CTRS was 9. There is negative correlation between CTRS score and hospitalization (i.e. < 9 indicates hospitalization and indicates that outpatient treatment would be suffi-

cient). This finding indicates that those hospitalized patients were more dangerous, had less social support and with little co-operativeness. These results were supported by the opinion adopted by Benglsdorf et al., (1993) where they reported that patients scoring from 3 to 8 on CTRS usually require hospitalization; those from 10 to 15 can usually be treated safely in the community. Approximately half of those scoring 9 might require hospitalization.

The difference between cut off score of our study (9) and that of Benglsdorf study (8) might be related to the sample populations and the setting in which they were assessed. Also, because of reluctance of our patients to continue on follow up in. Further research necessary to confirm the validity of this cut off score before applying it to other similar setting.

The dangerousness subscale of CTRS is the most discriminating in the decision to hospitalize, this was consistent with Gerson & Bassuk, (1983) in which the likelihood of harming one's self or others was the most influential factor when deciding whether or not to hospitalize patients who represented to the emergency room. The availability of family, friends and community support was the second most influential factor in the decision of admission. While the patients motivation and capacity to cooperate or participate in treatment contributed the least amount to this decision.

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- مثل الاضطراب التحولي النسبة الأكبر بين المترددين تلاه اضطراب العاطفة ثم الفصام وسوء استخدام العقاقير وكان الفصام أكثر شيوعاً بين مرضى الدخول.
- كانت هناك علاقة قوية بين درجات كل من "المقياس النفسى المختصر المتدرج" و "المقياس المتدرج للأزمات الطارئة" وقرار الدخول إلى المستشفى حيث كان الفاصل الرقمى (٥٤) فى الأول و(٩) فى الثانى.