

1 **DOI: <https://doi.org/10.47391/JPMA.08-805>**

2
3 **Pattern of presentations at psychiatric emergency services of a**
4 **public sector tertiary care hospital, Pakistan**

5
6 **Rida Hanif, Muhammad Iqbal Afridi, Jawed Akbar Dars, Fariha Iqbal**

7 Department of Psychiatry, Jinnah Postgraduate Medical Centre, Karachi, Pakistan

8 **Correspondence:** Rida Hanif. **Email:** dr.rida18@gmail.com

9
10 **Abstract**

11 **Objective:** To determine the pattern of presentations and characteristics of
12 patients at a psychiatric emergency services facility.

13 **Methods:** The cross-sectional study was conducted in November 2016 at the
14 Department of Psychiatry and Behavioural Sciences, Jinnah Postgraduate
15 Medical Centre, Karachi, and comprised all patients presenting to the
16 departmental emergency services. Data was documented on a pre-designed semi-
17 structured proforma, and analysed using SPSS 22.

18 **Results:** Of the 316 cases, 162(51.3%) were males and 154(48.7%) were females.
19 The overall mean age was 30.78+/-13.09 years (range: 8-80 years). Psychiatric
20 emergencies comprised suicidal attempt, excitement, violence, altered sensorium,
21 altered/ inappropriate behaviour and extrapyramidal symptoms / acute dystonia
22 together constituting for 123(38.9%) of the total presentations, while there were
23 20(6.33%) cases of hysterical fits and 6(1.89%) with acute anxiety symptoms.
24 Overall, 56(17.7%) subjects were found to have no psychiatric diagnosis, and
25 46(81.5%) of these were referred cases.

26 **Conclusion:** Non-emergency visits constituted high percentage of emergency
27 presentation.

28 **Key Words:** Psychiatry, Emergencies, Referral, Violence, Dystonia.

29 **Introduction**

30 Psychiatric emergencies in which an individual remains unable to refrain from
31 behaving in a manner that could be dangerous to self or others may include acute
32 excitement and agitation with self-destructive or suicidal behaviour^{1,2}. Generally,
33 prevalence rate of psychiatric emergencies is 10-60% in non-psychiatric medical
34 facilities². The challenging cases for emergency department (ED) physicians
35 include suicidality and self-destructive behaviour accounting for up to 15% of
36 psychiatric emergencies^{3,4}. ED physicians need to have considerable knowledge
37 and expertise as various conditions can present with psychomotor excitement and
38 agitations, ranging from organic disease to a variety of mental illnesses which
39 need to be managed accordingly⁵.

40 Patients with non-emergency psychiatric conditions also avail psychiatric
41 emergency services (PES)⁶⁻⁹ which might be because of the prevailing stigma¹⁰
42 regarding mental illnesses that makes them consult psychiatrist in emergencies
43 instead of regular psychiatric clinics. Similar pattern was noted in a study in
44 Canada where only 57% of the visits to PES were pertinent and urgent¹¹. Human
45 resources in mental health profession are not expanding in proportion to
46 increasing burden of mental illnesses and it is worse in developing countries like
47 Pakistan¹². In Pakistan, there are approximately 0.185 psychiatrist and 2.08
48 mental health outpatient facilities per 100,000 population¹³.

49 With changing time and de-institutionalisation of mental healthcare in the 21st
50 century, population availing PES is getting more complex, ranging from
51 'revolving-door' patients to 'first-timers' which along with wrong referrals may
52 hinder the quality treatment-based approach¹⁴.

53 Data about the pattern of patients presenting to PES of public-sector tertiary care
54 hospitals in Pakistan is limited. The current study was planned to fill the gap by
55 determining the pattern of presentations and characteristics of patients at PES of
56 a public-sector tertiary care hospital.

57

58 **Subjects and Methods**

59 The observational cross-sectional study was conducted in November 2016 at the
60 Department of Psychiatry and Behavioural Sciences, Jinnah Postgraduate
61 Medical Centre (JPMC), Karachi, which is a public-sector tertiary care and
62 teaching hospital providing 24-hour PES for both direct walk-ins and patients
63 referred from other departments including the ED.

64 After approval from the institutional review board and consent from the subjects,
65 data was collected through consecutive sampling by on-duty psychiatry residents,
66 registering all patients presenting to PES. Those excluded were patients who
67 presented to the outpatient department (OPD) of the setting which comprises two
68 general OPDs comprising lasting 4.5 hours twice a week, and 2 hourly special
69 clinics once a week. The particulars of all the cases were documented on a pre-
70 designed semi-structured proforma. This included total number of patients
71 presenting to PES, both direct walk-ins and psychiatric referrals from ED or other
72 departments, their socio-demographic particulars like age, gender, educational
73 status, occupation, marital status, mother tongue and residence with number of
74 accompanied persons, source and reason of referral, chief presenting complaints
75 and provisional psychiatric diagnosis according to International Classification of
76 Diseases version 10 (ICD-10)¹⁵ or Diagnostic and Statistical Manual of Mental
77 Disorders version 5 (DSM-V)¹⁶. Most of the patients were managed without
78 hospitalisation and were advised to follow up in the OPD, while a few of them
79 needed inpatient care and were admitted.

80 Tentative diagnosis was given by the residents-in-training and the senior
81 supervisor using DSM-V criteria of the American Psychiatric Association 2013¹⁶,
82 and ICD-10¹⁵. Broad diagnostic categories used were: organic psychosis
83 comprising mental disorders due to a medical condition; substance use disorders;
84 thought disorder including schizophrenia, schizotypal, delusional disorders, and
85 acute psychotic disorder; mood disorders; neurotic disorders like anxiety, stress-
86 related, dissociative and somatoform conditions; mental retardation / intellectual

87 disability; deferred axis 1 diagnosis; and other diagnoses. Patterns of referral
88 included internal and external referrals to the PES. Internal referrals consisted of
89 patients who presented first to an ED physician who assessed the presented
90 complaints to treat any medical problem that may need immediate attention. If
91 the ED physician felt that psychiatric assessment was needed or a psychiatric
92 consultation was requested, the PES was contacted. External referrals were
93 directly referred to the PES and the following categories were used: referrals by
94 healthcare professionals, like general practitioners or other hospitals, referrals by
95 family members, friends, police referrals, and self-referrals i.e. on their own.
96 Time at which the patient presented was also noted.

97 Data was analysed using SPSS 22. Central tendencies, including mean, range and
98 standard deviation of quantitative variables age and number of attendants of
99 patients were computed. Frequencies and percentages of all categorical variables
100 were calculated. Categorical variables were analysed with chi-square test. $P < 0.05$
101 was considered statistically significant.

103 **Results**

104 Of the 316 cases, 162(51.3%) were males and 154(48.7%) were females. The
105 overall mean age was 30.78 \pm 13.09 years (range: 8-80 years). Across varying
106 ages, 284(89.9%) were accompanied by mean number of attendants 2 \pm 1.35
107 (range: 1-9), while 32(10.1%) came on their own.

108 Cases usually presented during daylight hours from 9am to 6pm 250(79.2%),
109 while 48(15.2%) presented between 8pm to 8am, and 17(5.4%) presented after
110 midnight, presenting with altered sensorium 1(5.9%), somatic symptoms
111 5(29.4%), headache 5(29.4%), suicidal attempt 1(5.9%), altered / inappropriate
112 behaviour 3(17.6%) and others 2(11.8%). Among these 17 cases, 6(35.3%) came
113 directly to PES, while 11(64.7%) were referred cases, and, among them, 8(47.1%)
114 had no psychiatric diagnosis.

115 The socio-demographic details of all the cases were noted and compared along
116 gender lines (Table 1).

117 Overall, 182(57.6%) cases were internal referrals either from ED 103(32.6%) or
118 departments like General Medicine 8(2.5%), General Surgery 2(0.6%),
119 Neurology 17(5.4%), Neurosurgery 5(1.6%), Chest Medicine 1(0.3%) and Eye
120 1(0.3%), while 134(42.4%) came directly to the PES as external referrals,
121 including 55(41.04%) who came as self-referral, 65(48.5%) were brought by
122 family, 5(3.7%) by friends, 5(3.7%) had been referred by general practitioners
123 and 4(2.98%) by other hospitals.

124 Reasons for referral included predominant psychiatric symptoms in 108(34.2%),
125 no physical illness was detected in 23(7.3%), mental symptoms coexisted with
126 physical illness in 29(9.2%), old case of psychiatric illness 27(8.5%), to rule out
127 psychiatric illness 105(33.2%), organic illness insufficient to explain symptoms
128 6(1.9%) and detoxification or others 18(5.7%).

129 Various presenting complaints were noted (Table 2).

130 Provisional diagnosis at PES included mood disorders 104(32.9%), followed by
131 neurotic disorders 62(19.6%) and thought disorders 41(13.0%) (Table 3).

132 Among cases of mood disorders, 18(5.7%) had bipolar disorder, 15(4.7%) manic
133 disorder and 71(22.5%) had depressive disorder. Substance use disorder included
134 cannabinoids use 6(1.9%), opioid use 9(2.8%), benzodiazepine use 1(0.3%), and
135 multiple substance use 7(2.2%). Thought disorders included cases of
136 schizophrenia 25(7.9%), delusional disorder 1(0.3%) and acute psychotic
137 disorder 15(4.7%). Neurotic disorder included stress-related disorders 9(2.8%),
138 conversion disorder 31(9.8%), generalised anxiety disorder 12(3.8%), panic
139 disorder 1(0.3%), obsessive compulsive disorder (OCD) 4(1.3%), somatoform
140 disorder 5(1.3%), and others 1(0.3%).

141 People with intellectual disability 4(8.33%) presented aged 13-18 years, the age
142 group in which 15(31.25%) cases presented with neurotic disorders, followed by

143 others. Mood disorders 49(33.33%) and 45(38.46%) followed by neurotic
144 disorder 31(21.09%) and 16(13.67) were found in age groups 19-30 years and
145 >30 years respectively (p=0.180).

146 Overall, 54(17.09%) cases had no psychiatric illness; 44(81.5%) of them were
147 referred cases, while 10(18.5%) had come directly to PES. Among 105(33.2%)
148 cases that had been referred to rule out psychiatric illness, 40(38.1%) were found
149 to have no psychiatric illness.

150 Statistically significant association was found between psychiatric diagnoses and
151 gender (p=0001) as well as occupation (p=0.038).

152

153 **Discussion**

154 The number of people availing PES is increasing despite the prevailing stigma
155 about mental illnesses¹⁰ and this was also observed in the current study where
156 people consulted PES even without having been referred to do so. The utilisation
157 of PES could be the result of awareness of availability of such services through
158 print and social media or other means, and not merely the knowledge about
159 psychiatric illness, as in total 17% had no psychiatric issues out of which 81.4%
160 had been referred cases from ED or other departments. The referrals were made
161 by physicians and reflect their knowledge about psychiatry. Approximately one-
162 third (33.2%) of the cases were referred to rule out psychiatric illnesses among
163 which 38% didn't suffer from any psychiatric illness, which is similar to the
164 findings of a study at a North America ED¹⁷.

165 A significant number (42.4%) presented to PES directly without referral,
166 depicting decreasing stigma and increasing concern and awareness regarding
167 psychiatric diseases in the general population¹⁸.

168 Among people availing psychiatric services, males (51.3%) were more than
169 females (48.7%) which was similar to a study in India⁷. More utilization of PES
170 by males could either be due to stigma related to the field that lead to

171 underutilisation of services for psychiatric disorders among females, or
172 convenience of seeking consultation after working hours as majority of the
173 presented males (31.48%) were working as unskilled worker or labourer while
174 females were mostly confined to the households as housewives (75.97%). The
175 same trend was found almost a decade back in a study¹⁹ done in similar settings.
176 Most (46.5%) of the cases were young aged 19-30 years, which is similar to a
177 study in India⁷. Overall, 49.38% males were single while 60.39% females were
178 married who utilised PES, indicating that marriage, might be due to marital
179 conflicts, is a risk factor for developing psychopathology among females
180 compared to males in our part of the world^{20, 21}.

181 Around 90% cases were accompanied by varying number of attendants that
182 shows good social and moral support system in our culture. Approximately 13%
183 cases were from the other cities of the province and other provinces of the
184 country, which indicates good communication skills of doctors with also a bit of
185 knowledge about other native languages to develop a better doctor-patient
186 relationship.

187 Overall, the most common presenting complaints were somatic symptoms
188 78(24.68) followed by altered or inappropriate behaviour 75(23.7%), which is
189 similar to a study conducted in India²².-Majority (23.38%) of females presented
190 with altered or inappropriate behaviour, while somatic symptoms were presenting
191 complaints of most males. Ratio of cases of suicide attempts that had been
192 referred for evaluation to PES was same for both gender.

193 Mood disorder was the most common diagnosis at the PES, followed by neurotic,
194 stress-related, anxiety and somatoform disorders which is in line with previous
195 studies done in Karachi^{6,19}, other cities of Pakistan²³ and also in the United
196 States²⁴. The finding, however, is contrary to studies in India²² and Italy⁸.
197 Substance use disorder was found exclusively among males, which was similar
198 to a study¹⁹ done at the same hospital, showing no change over the course of
199 years.

200 Most of the adult population (19 years and above) that availed PES had mood
201 disorders, while adolescents (<19 years) presented with neurotic disorders,
202 including stress-related, conversion disorder, OCD and other anxiety disorders.
203 A study in Pakistan also concluded that depression was more common among
204 adult population²⁰ similar to a survey done in the US²¹.

205 PES was usually availed during daylight hours and only a small number (5.4%)
206 presented after midnight among which majority (47.1%) had no psychiatric
207 illness and were either referred for delirious states which usually got confused as
208 psychiatric illnesses due to their behavioural symptoms or altered sensorium
209 secondary to other medical conditions that needed to be investigated and treated
210 accordingly.

211 True psychiatric emergencies included suicidal attempt (1.26%), unnecessary
212 excitement (4.11%), violence (4.11%), altered sensorium (5.06%), altered /
213 inappropriate behaviour (23.7%) and extrapyramidal symptoms / acute dystonia
214 (0.63%) together constituting 38.9% of the total. Other situations that can also be
215 considered emergencies were hysterical fits (6.33%) and acute anxiety symptoms
216 (1.89%). Thus, only 47.09% cases were the actual emergency psychiatric visits,
217 while others were non-emergency visits that could be delayed to be consulted in
218 OPD. Similar results were found in a study conducted in Canada²⁵. Among all
219 pertinent and urgent cases, around 50-60% were diagnosed with an affective or a
220 psychotic disorder, often with a suicidal content²⁵.

221 There is need for standardised guidelines for ED physicians and psychiatrists
222 based on primary evidence regarding management of psychiatric emergencies²⁶.

223 The current study has its limitations. It's findings cannot be generalised as it is a
224 single-setting study of short duration. Also, only main or primary psychiatric
225 diagnoses were included, while dual or co-morbid diagnoses were not included.

226

227

228 **Conclusions**

229 Non-emergency visits constituted high percentage of PES presentation, which
 230 can hinder the process of providing services to actual emergencies. Besides,
 231 wrong referrals to PES can delay the management that would be needed in cases
 232 of non-psychiatric medical conditions. Knowledge regarding common
 233 psychiatric disorders among ED physicians is needed.

234

235 **Disclaimer:** None.

236 **Conflict of Interest:** None.

237 **Source of Funding:** None.

238

239 **References**

- 240 1. Newman M, Ravindranath D. Managing a Psychiatric Emergency: What
 241 Every Psychiatrist Needs to Know. [cited on 18th May, 2017] Available
 242 from [https://pro.psychcentral.com/managing-a-psychiatric-emergency-
 243 what-every-psychiatrist-needs-to-know/00416.html](https://pro.psychcentral.com/managing-a-psychiatric-emergency-what-every-psychiatrist-needs-to-know/00416.html)
- 244 2. Mavrogiorgou P, Brüne M, Juckel G. The management of psychiatric
 245 emergencies. *Dtsch Arztebl Int.* 2011 Apr; 108(13):222–30
- 246 3. Kropp S, Andreis C, Tewildt B, Sieberer M, Ziegenbein M, Huber TJ.
 247 Characteristics of psychiatric patients in the accident and emergency
 248 department (ED). *Psychiatr Prax.* 2007 Mar; 34(2):72-5.
- 249 4. Fähndrich E, Neumann M. The police in psychiatric daily routine.
 250 *Psychiatr Prax.* 1999 Sep; 26(5):242-7.
- 251 5. Guedj MJ. Emergency situations in psychiatry. *Rev Prat.* 2003 Jun 1;
 252 53(11):1180-5.
- 253 6. Shahid M, Khan MZ, Ejaz K, Nakeer R, Iftikhar S. Profile of psychiatric
 254 patients presenting to a tertiary care emergency department of Karachi. *J
 255 Coll Physicians Surg Pak* 2015. Vol.25(5):386-88

- 256 7. Adhikari P, Niranjan A, Ahuja SK. Assessment of socio-demographic
257 determinants of psychiatric patients attending psychiatry outpatient
258 department of a tertiary care hospital of Central India. *Int J Community*
259 *Med Public Health*. 2016;3(3):764-69
- 260 8. Anastasi S, Eusebi P, Quartesan R. Psychiatry in the emergency room:
261 one-year period of clinical experience. *Psychiatr Danub*. 2014 Nov;26
262 Suppl 1:56-65.
- 263 9. Ghanbari Jolfaei A, Nasr Isfahani M, Shoyookhi F. Characteristics of
264 psychiatric visits to the emergency department of Rasoul-e-Akram
265 hospital, Tehran, Iran. *Iran J Psychiatry Behav Sci*. 2012 Fall;6(2):42-7.
- 266 10. World Health Organization. Facts on Mental Health [cited on January 12th,
267 2017] Available from
268 [http://www.who.int/features/factfiles/mental_health/mental_health_facts/
269 en/index5.html](http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index5.html)
- 270 11. Chaput Y, Paradis M, Beaulieu L, Labonté E. A qualitative study of a
271 psychiatric emergency. *Int J Ment Health Syst*. 2008 Jun 30;2(1):9. doi:
272 10.1186/1752-4458-2-9.
- 273 12. World Health Organization. Global Health Observatory (GHO) data [cited
274 January 12th,2017] Available from:
275 [http://www.who.int/gho/mental_health/human_resources/psychiatrists_nu
276 rses/en/](http://www.who.int/gho/mental_health/human_resources/psychiatrists_nurses/en/)
- 277 13. World Health Organization. Mental Health Atlas 2011 for Pakistan [cited
278 January 12th, 2017] Available from
279 [http://www.who.int/mental_health/evidence/atlas/profiles/pak_mh_profil
280 e.pdf?ua=1&ua=1](http://www.who.int/mental_health/evidence/atlas/profiles/pak_mh_profile.pdf?ua=1&ua=1)
- 281 14. Bruffaerts R, Sabbe M and Demyttenaere K. Emergency psychiatry in
282 the 21st century: critical issues for the future. *European Journal of*
283 *Emergency Medicine*.2008,15:276–78

- 284 15. World Health Organization. (1992). The ICD-10 classification of mental
285 and behavioural disorders: Clinical descriptions and diagnostic guidelines.
286 Geneva: World Health Organization.
- 287 16. American Psychiatric Association. (2013). Diagnostic and statistical
288 manual of mental disorders (5th ed.).
289 <https://doi.org/10.1176/appi.books.9780890425596>
- 290 17. Tucci V, Siever K, Matorin A. Down the rabbit hole: Emergency
291 department medical clearance of patients with psychiatric or behavioural
292 emergencies. *Emerg Med Clin North Am.* 2015 Nov;33(4):721-37.
- 293 18. Schulze B. Stigma and mental health professionals: A review of the
294 evidence on an intricate relationship. *International Review of Psychiatry*
295 [Internet]. Informa UK Limited; 2007 Jan;19(2):137-55. Available from:
296 <http://dx.doi.org/10.1080/09540260701278929>
- 297 19. Khan AG, Rahman R, Ansari M, Hayder Z, Hussain M. Pattern of
298 psychiatric emergencies at tertiary care hospital in Karachi. *JPPS.*
299 2010;7(1):37-41
- 300 20. Shakoor A, Taimuri SZ, Akhtar MAB. Prevalence of depression and
301 associated risk factors in patients belonging to low socio-economic status.
302 *PJMHS.* Oct-Dec 2015;9 (4):1197-1201
- 303 21. Bhamani S, Zahid N, Azam I, Asad N, Karmaliani R. and Pasha O.
304 Association of depression and life satisfaction with low resilience among
305 married women of Karachi, Pakistan. *Open Journal of*
306 *Epidemiology.* 2015;5:251-59. doi: 10.4236/ojepi.2015.54029.
- 307 22. Keertish N, Sathyanarayana MT, Kumar BGH, Singh N, Udagave K.
308 Pattern of psychiatric referrals in a tertiary care teaching hospital in
309 southern India. *JCDR.* 2013 Aug ;7(8);1689-91.
- 310 23. Yousafzai AW, Jehangiri AR, Kazim M, Shah M. Demographic and
311 clinical characteristics of patients referred to psychiatric unit in a tertiary
312 care hospital. *J Ayub Med Coll Abbottabad.* 2015;27(1):208-11

- 313 24. Sami Walid, M., Zaytseva, N. and Perez, W. The psychiatric profile of the
 314 U.S. patient population across age groups. Open Journal of Epidemiology.
 315 2012;2;37-43.
- 316 25. Chaput Y, Paradis M, Lucie B, Labonte E. A qualitative study of a
 317 psychiatric emergency. Int J Ment Health Syst. June 2008; 2:9
 318 doi:10.1186/1752-4458-2-9
- 319 26. Nadkarni A, Hanlon C, Bhatia U, Fuhr D, Ragoni C, de Azevedo Perocco
 320 SL, et al. The management of adult psychiatric emergencies in low-
 321 income and middle-income countries: a systematic review.
 322 Lancet Psychiatry. 2015 Jun;2(6):540-7.

323
 324 -----
 325
 326

Table 1: Socio-demographic characteristics with respect to gender (n=316).

SOCIODEMOGRAPHIC CHARACTERISTICS OF PATIENTS	Male		Female		TOTAL		P Value
	N	%	N	%	N	%	
Age group (years)							
<19	28	17.3	24	15.6	52	16.5	0.916
19 – 30	75	46.3	72	46.75	147	46.52	
>30	59	36.42	58	37.66	117	37.02	
Marital status							
Single	80	49.38	46	29.87	126	39.87	0.001
Engaged	1	0.62	2	1.3	3	0.95	
Married	77	47.53	93	60.39	170	53.8	
Divorced / Widowed	4	2.47	13	8.44	17	5.38	
Educational Status							
Preliterate	54	33.33	78	50.65	132	41.77	0.053
Primary	40	24.69	34	22.08	74	23.42	
Matric	41	25.31	25	16.23	66	20.88	
Intermediate	15	9.26	9	5.84	24	7.59	
Graduation or above	11	6.79	7	4.54	15	4.75	
Others	1	0.62	1	0.65	2	0.63	
Occupational status							
Unemployed	48	29.6	11	7.14	59	18.67	0.000
Student	15	9.26	13	8.44	28	8.86	
Household	2	1.23	117	75.97	119	37.65	
Unskilled worker/ Laborer	51	31.48	6	3.9	57	18.04	

Skilled worker	39	24.07	3	1.95	42	13.29	
Professional / Doctor/ Engineer	1	0.62	3	1.95	4	1.26	
Police/ Ranger/ Law Enforcement Agencies	1	0.62	0	0	1	0.32	
Others	5	3.09	1	0.65	6	1.9	
Mother Tongue							
Urdu	73	45.06	65	42.21	138	43.67	
Sindhi	26	16.05	32	20.78	58	18.35	0.883
Pashto	33	20.37	31	20.13	64	20.25	
Punjabi	15	9.26	15	9.74	30	9.5	
Balochi	3	1.85	3	1.95	6	1.9	
Others	12	7.41	8	5.19	20	6.33	
Residence							
Karachi	135	83.33	138	89.6	273	86.39	
Sindh	13	8.02	10	6.49	23	7.28	0.518
Punjab	3	1.85	2	1.3	5	1.58	
Baluchistan	2	1.23	2	1.3	4	1.26	
KPK	7	4.32	2	1.3	9	2.84	
Gilgit Baltistan	1	0.62	0	0	1	0.32	
Others	1	0.62	0	0	1	0.32	
Total	162	100	154	100	316	100	

327 KPK: Khyber Pakhtunkhwa.

328

329 -----

330

331 **Table 2: Complaints at the time of presentation. (n= 316)**

<i>Presenting Complaints</i>	<i>Male</i>		<i>Female</i>		<i>Total</i>		<i>P value</i>
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	
<i>Altered/Inappropriate Behaviour</i>	39	24.07	36	23.38	75	23.73	
<i>Epileptic Fits</i>	4	2.47	4	2.6	8	2.53	
<i>Acute Anxiety Symptoms</i>	2	1.23	4	2.6	6	1.89	
<i>Acute Dystonia/ EPS</i>	2	1.23	0	0	2	0.63	
<i>Low mood</i>	9	5.55	21	13.64	30	9.49	
<i>Suicidal Attempt</i>	2	1.23	2	1.3	4	1.26	

<i>Headache</i>	15	9.26	21	13.64	36	11.39	0.133
<i>Somatic Symptoms</i>	46	28.39	32	20.78	78	24.68	
<i>Hysterical Fits</i>	8	4.94	12	7.79	20	6.33	
<i>Altered Sensorium</i>	7	4.32	9	5.84	16	5.06	
<i>Violence</i>	9	5.55	4	2.6	13	4.11	
<i>Excitement</i>	9	5.55	4	2.6	13	4.11	
<i>Other</i>	10	6.17	5	3.25	15	4.75	
<i>Total</i>	162	100	154	100	316	100	

332 EPS: Extrapyrimal symptoms

333

334

335

336 **Table 3: Comparison of psychiatric disorders in both genders (n=316).**

<i>Provisional Diagnosis Made at PES</i>	<i>Male</i>		<i>Female</i>		<i>Total</i>		<i>P Value</i>
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	
<i>Substance Use Disorder</i>	23	14.2	0	0	23	7.28	0.000
<i>Thought Disorder</i>	24	14.8	17	11.04	41	12.97	
<i>Mood Disorder</i>	47	29.01	57	37.01	104	32.9	
<i>Neurotic</i>	23	14.2	39	25.32	62	19.62	
<i>Intellectual disability</i>	6	3.7	4	2.6	10	3.16	
<i>Organic Psychosis</i>	0	0	4	2.6	4	1.26	
<i>Diagnosis Deferred</i>	7	4.32	4	2.6	11	3.48	

<i>Others</i>	3	1.85	4	2.6	7	2.21
<i>No Psychiatric Diagnosis</i>	29	17.9	25	16.23	54	17.09
<i>Total</i>	162	100	154	100	316	100

337

338

339

Provisionally Accepted for Publication