

Clinical profiles of patients within the Mental Health Service in Qatar

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Submitted: 23 Oct 2020; Accepted: 05 Nov 2020; Published: 16 Nov 2020

Abstract

Aim: The aim of this study was to explore the clinical profile of patients referred to the only dedicated Psychiatry Hospital in Qatar over a one-year period in order to understand the clinical needs of these patients.

Methods: We examined, retrospectively, the records of patients who presented to the Emergency Department in Hamad General Hospital with psychiatric problems and needed psychiatric assessment in the period between 1st of June 2015 to 31st of May 2016. We reviewed the records of 870 patients within one year from both electronic records and paper records.

Results: Patients from 48 different nationalities presented to the Emergency Department with a psychiatric presentation. Patients who presented spoke 22 different languages. Clinical presentations covered a wide spectrum of stress related disorders. The most common diagnosis was bipolar affective disorder, depressive disorder and schizophrenia.

Conclusion: This study gives a window into the clinical profiles of those who present with acute mental illness and highlights some risk factors to be aware of in treating such patients. The variety of cultures and languages of patients is important to recognize and emphasizes the ongoing need for adequate language translation for appropriate psychiatric evaluation of these patients.

Introduction

The aim of this study was to explore the clinical profile of patients referred to the only dedicated Psychiatry Hospital in Qatar over a one-year period in order to understand the clinical needs of these patients. Qatar is a sovereign Arab state on the Qatar Peninsula of the Arabian Peninsula. It is one of the wealthiest countries in

the world. It is known for oil trade, natural gas and sea trade, and has recently undergone rapid urbanization. As of March 7, 2019, the population of Qatar was 2,728,012, based on the latest United Nations estimates where Qatari's nationals represent less than 20% of the population [1].

Hamad Medical Corporation (HMC), established by Emiri decree in 1979, is Qatar's premier non-profit health care provider. Located in the State of Qatar, HMC manages eight hospitals and operates both the national ambulance service and a home healthcare service. HMC is the only healthcare organization outside the United States to receive simultaneous Joint Commission International (JCI) re-accreditation for all its hospitals. In 2011, the ambulance service and home healthcare service also received JCI accreditation [2].

The Psychiatry Hospital in this corporation is the main provider of a mental health service and the only hospital in Qatar with acute inpatient psychiatry units. The acute wards accommodated total of 79 patients around two third of them for males. Approximately 100 people with severe mental health problems are seen daily at the Hamad Medical Corporation's (HMC) Psychiatry Hospital and assessed either by the Consultation Liaison Team or as emergency referrals at the Emergency Clinic, and more recently at Al Wakra and Hazem Meberiek Hospital. In addition, the Mental Health Service operates a day care service for adults, and an expanding community service for children, adults, the elderly and offers specialist forensic and learning disability services.

Referrals to the Psychiatry Hospital include those for emergency admission and outpatients. For example, over a three-and-a-half-month period, 312 patients were seen for emergencies, many with acute psychosis [3]. Within the adult out-patient clinic patients mostly suffer from depression, anxiety disorder as well as psychotic conditions such as schizophrenia.

Most studies and case reports on psychiatry patients so far published have been in selected specific populations. Less than 15 similar studies have been conducted worldwide, each one had different conclusions on the limitations and outcomes according to the region and the available services. One of the largest studies to date was conducted in New South Wales in Australia, a data of 17 years describing clinical profiles of different health problems including mental health [4].

The purpose of this mental health study was to understand and reduce the premature mortality among mental health patients by understanding the referral patterns and clinical symptom profiles of those within the Mental Health Service [4]. Considering the different backgrounds of the population and its rapid growth, we aimed to have a retrospective holistic look to the clinical profile of patients presenting to the psychiatric service in Qatar. We considered that the insight so gained might help the mental health professionals in Qatar to make a better-informed plan to implement the improved service and the patient care in line with the ambition of the Qatar Mental Health Strategy (2013-2022).

Materials and Methods

Study Methodology

We examined, retrospectively, the records of patients who presented to the Emergency department in Hamad General Hospital (HGH) with psychiatric problems and who needed psychiatric assessment in the period between 1st of June 2015 to 31st of May 2016. Using clinical information obtained at assessment, we noted the patient's demographics (age, gender, date of assessment, nationality and occupation), the means by which patients were

brought to the hospital, the informant, what language spoken and whether an interpreter was needed. We also noted the key features of the history and mental state in addition to the differential diagnosis and initial treatment plan.

Study Population and Study Setting/ Location

Inclusion Criteria:

1. The files and electronic records of patients who presented to the Emergency department in HGH were assessed by the psychiatry on-call doctor in the period between 1st of June 2015 to 31st of May 2016 outside working hours (3pm-7:00 am next day, weekends and official holidays).
2. Patients were adults aged 18 years or older.

Exclusion criteria:

1. Patients seeking psychiatric services who presented to facilities other than the Emergency Department of HGH.
2. Patient below 18 years old of age.
3. Patients presented before and after the period between 1st of June 2015 to 31st of May 2016.
4. Patients presented between 1st of June 2015 to 31st of May 2016 to the Emergency department of HGH who were not assessed by the psychiatry on call doctor. Patients seen by another psychiatrist who was not on call during this period.

Statistical Consideration and Data Analysis

The collected data was entered into two secured laptops for analysis by the SPSS program. Descriptive statistics in the form of mean and standard deviation for interval variables and frequency with percentages for categorical variables were performed including all demographics of patients presenting to HGH emergency for psychiatric assessment, different psychiatric presentations of patients, diagnosis, and the disposition of patients.

Results

Demographics of the sample:

We managed to review the records of 870 patients within one year from both electronic records and paper records, 65% (565) are males. The mean age of the sample was 33 years, as many of them are young male workers (Figure 1).

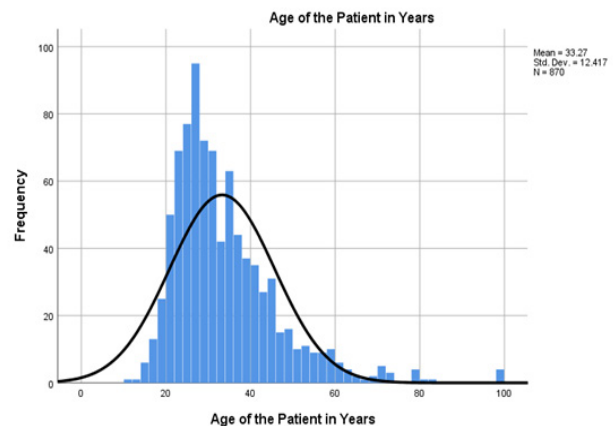


Figure 1: histogram represents age of patients presented to the Emergency in years

Patients from 48 different nationalities presented to the ED of HMC with a psychiatric presentation. Most of them were nationals 36% (n=285), Indians 14% (n=113) and other Asian populations 23% (n=188) (Figure 2).

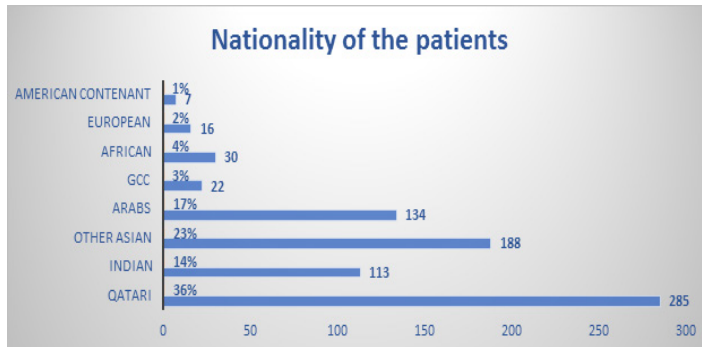


Figure 2: bar chart describes the percentages of nationalities of patients presented to the Emergency Department

Patients presenting to the ED spoke 22 different languages and 24% of the patients needed interpreters. The commonest spoken language after Arabic and English was Hindi and Urdu representing 9% (66). Around 30% of the males (n=142) and 13% of the females (n=30) needed interpreters for the psychiatric interviews.

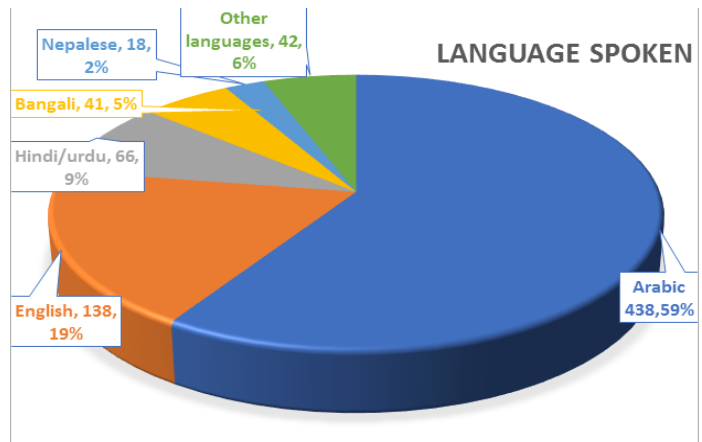


Figure (3): pie chart describes the top 5 languages spoken by the patients presented to the Emergency Department

Majority of the patients group were not employed 31% (n=206). Most of the employed population were manual workers 22% (n=146) or service occupations 19% (n=141) (Figure 4 in the appendix). There was difference in occupational profile between males and females, most of the males were manual workers 48% (n=188), More than half of females were not either (either housewives or unemployed) 51% (n=120), however most of the employed ones were working as housemaids 20% (n=46).

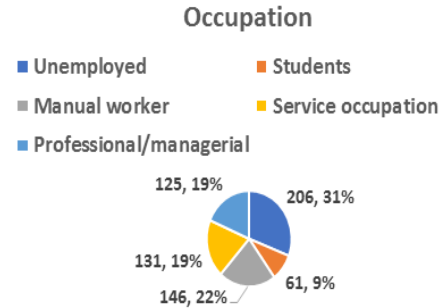


Figure 4: pie chart represents the percentages occupation status of patients presented to the Emergency Department

Presentations and clinical complaints

Around one fifth of our sample were brought to the ED by the police and one fifth, by ambulance. Around two-fifths were brought by family members and the rest were brought by friends, work colleagues or they were self-referrals (Figure 5) in the appendix.

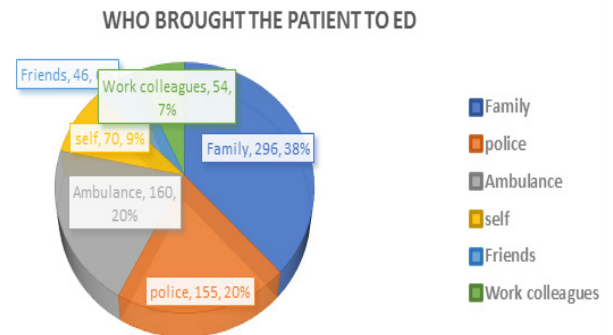


Figure 5: pie chart describes percentages of whom brought the patient to the Emergency Department

Around half of our sample 46% (n= 406) the main complaint was abnormal behavior, which included aggressive and irritable behavior towards others. About a quarter of patients presented with self-injurious thoughts or acts 23% (n=200). Table (1) shows the presenting complaints.

Table 1: describes the percentages of the presenting complaints of patients came to the Emergency Department

Complaint	%
Abnormal behavior (includes aggression and irritability)	46%(406)
Self injurious thoughts or acts	23%(200)
Sleep problems	7%(57)
Mood changes	7%(62)
Non-psychiatric complaints	8%(69)
Criminal case	3%(27)
Paranoia/suspicion	1%(7)
Other complaints	5%(46)

Table 2: represents the percentage of the prominent symptoms of patients presented to the Emergency Department

Symptoms	%
Self-harm thoughts	37% (180)
Hearing voices	24% (164)
Persecutory delusions	21% (133)
Grandiose delusions	8.65% (52)

Three fifths of our patients had a previous history of psychiatric disorder 59% (n=449); around one third of them were previously admitted to the Mental Health Hospital 35% (n=199) (Table 3 & 4 in the appendix).

Table 3: represents the percentage of risky behavior of patients presented to the Emergency Department

Risky behavior	%
Self-injury	24% (171)
Risk to others	27% (187)

Table 4: represents the percentage of past psychiatric history of patients presented to Emergency Department

	%
Past psychiatric history	59% (449)
Previous admission to psychiatry hospital	35% (199)
Discharged within past week	7% (44)

In the mental state examination, around a quarter of our patients were uncooperative during the psychiatric interview 23% (n=153) (Table 5 in the appendix).

Table 5: represents the percentage of behavioral state of patients presented to the Emergency Department

Behavioral state	%
Abnormal behavior observed	35% (267)
Uncooperative behavior observed	23% (153)
In restraint	4% (28)

Table 6: shows the different diagnosis of psychiatry patients presented to the Emergency Department

Diagnosis	%
Schizophrenia	12.4% (108)
Acute and transient psychosis	9% (79)
Substance use related disorders	5% (46)
Delirium	4% (33)
Bipolar affective disorder (Manic)	15% (133) ,(10% (91))
Depressive disorder	12.6% (110)
Anxiety disorder	6% (50)
Adjustment disorder	8% (69)
Dissociative disorder	1.3% (12)
Deliberate self-harm	3% (27)
Other diagnosis	23% (201)
No clear diagnosis	12.6% (110)

The most common diagnosis in our sample was bipolar affective disorder 15% (n=133); around two third of whom were manic 10% (91). Depressive disorders and schizophrenia were also common. Most of the patients presenting to the ED were admitted to the Psychiatry Hospital 54% (n=458) and around a quarter of them were discharged with OPD referrals 27% (n=238). 6% were referred to Emergency or medical team for further medical assessment and management, mostly for delirium or suspected delirium tremens. The outcome of clinical assessment is shown in Table (7).

Table 7: shows the assessment outcome of the psychiatry patients presenting to the Emergency Department

Assessment outcome	%
Admitted to hospital	54% (458)
Discharged home with outpatient referral	27% (238)
Further assessment in Emergency	10% (88)
Discharged against medical advice	2% (18)
Further medical assessment and management.	6% (48)

Discussion

Strengths and Limitations:

This study is one of the few studies from the Middle East and Africa which reports clinical profiles for almost all patients presenting to the Emergency Department with psychiatric symptoms over a complete year. It is noteworthy that our sample represents patients from 48 different countries speaking 22 different languages, which represents the multinational mix of Qatar.

It was helpful to understand better the referral patterns and clinical symptom profiles within the mental health service through a system in place such as a Registry. Such information informed us where to focus attention in further development of the service. In the Middle East there is one similar study done for refugees attending the neurology outpatient clinic but not for psychiatry patients. There is one similar study in India but nothing similar in the Middle East or Africa [5, 6].

We had many challenges in our data collection. During the year of 2016 medical records were switched from hard copies to electronic records which made it more difficult to include all the patients presented during this period. Another challenge that we faced is the missing identification records of some presented patients. A number of patients presented to the hospital with no ID and if they had a disturbed mental state with no collateral history it was difficult to get relevant information about them. These were excluded from our sample.

Interpreting our Findings

Although the population of Qatari nationals ranks 4th compared to other nationalities, they presented relatively more frequently to ED department. There are a number of different explanations. One of them is that people from other countries need to be healthy to work in Qatar, non-Qatari patients may be reluctant to present to the ED because they are afraid of losing their job, or they may present earlier to outpatients with milder symptoms before illness becomes severe. In order to verify this, similar studies would need to be conducted for patients presenting to the outpatient clinics and community facilities of the Mental Health Service.

It is noteworthy that many of the patients presented multiple times, 35% with previous admissions and around 7% (n=44) discharged within the past week. This may imply that, at least when this study was conducted, before community services were more developed, that patients may have been discharged prematurely or follow up plans were not robust. As the period immediately following discharge from hospital is a high-risk period, it is imperative that patients are engaged in community services before discharge from hospital [7].

Most of our sample were unemployed and the employed ones work in low paid jobs like labourers, security or housemaids. This section of the community is likely to be vulnerable to mental illness as unemployment and low socioeconomic status are recognized risk factors [8]. In addition, the lack of family support for some may make it more difficult for them to cope with stress [9].

The observation that relatively fewer females required an interpreter may indicate that a number of females work in families where local language is needed, whereas for many male workers, this is

not so necessary. However, most of our patients were brought to the Emergency Department by family members. At least for those permanent residents, this reflects the culture in this region where families tend to live in one house even after marriage. Furthermore, it reflects the social bond and support among family members in the predominant Arab and Muslim culture. On the other hand, 40% were brought in by police or ambulance, and 46% with abnormal behavior and aggression and 23 % with self-injurious thoughts or acts, all implying acute severe illness. Identifying those at risk early is important and here enhanced adult community services can help [10].

Summary and Recommendations

From our sample, those who presented to the ED with risky behaviour toward self or others were symptomatic for less than one month. This is a positive reflection of awareness among the people who live in Qatar, who are brought to the attention of clinical services within a reasonable timeframe. Early detection and treatment are essential for preventing the more severe acute and long-term consequences of mental illness [11].

The commonest mental health disorder in this series was bipolar affective disorder followed by depressive disorder and schizophrenia. This is not surprising given that the sample was highly selected to those patients acutely unwell considered for hospital admission. To ascertain mental illness prevalence and risk in the population, epidemiological population studies are needed.

Conclusion

Qatar is one of the rich developing countries which is working in improving the health system including mental health resources and community-based services. This study gives a window into the clinical profiles of those who present with acute mental illness and highlights some risk factors to be aware of in treating such patients. The variety of cultures and languages of patients is important to recognize and emphasizes the ongoing need for adequate language translation for appropriate psychiatric evaluation of these patients.

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