Original Article

Referrals to Psychiatry in a Rural Teaching Hospital

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ABSTRACT

Background: There is a pressing need to improve the Consultation-liaison (CL) psychiatry services both in hospitals and the community. In India General Hospital Psychiatric Units were established in 1930s, but CL psychiatry has never been the focus of training or research. Studying the referrals to psychiatry will be a useful indicator of psychiatric awareness among the clinicians and their intent to utilize the available services. Outcomes of such studies may give us new insights to develop the f eld of CL psychiatry.

Methodology: This study includes all the referrals to the department of psychiatry over a period of three years from the inpatient and outpatient services of other disciplines of the hospital. Collected data includes socio-demographic features, referral prof le and clinical details of the patients.

Observations and results: The referral rate is 0.18%. Of the 680 referrals, most of the referrals were from general medicine (65.7%), the commonest reason for referral being evaluation of abnormal behavior (24.2%). Psychiatric illness was found in 85.7% of the patients and the most common diagnosis was substance use disorders (21.5%).

Conclusion: In the present study the referral prof les indicate underutilization of the available psychiatric services. This warrants a probe into the reasons, as CL psychiatry is the key for the deliverance of comprehensive health care.

Keywords: Referral rate, CL psychiatry, GHPU

Introduction

Psychiatry has come a long way as a medical discipline, despite the challenges posed by stigma and superstition. Asylums have become archaic and the days of restraint with chains are passe.

During the last century, to bring psychiatry closer to the people, psychiatry units were established in general hospitals. The f rst General Hospital Psychiatry Unit (GHPU) was established at Albany Hospital (USA) in 1902. In India, Dr Girindra Sekhar established one in 1933 at R.G. Kar Medical College and Hospital, Calcutta.[1]

Psychiatric units in the general hospitals gave increased opportunities for interaction between psychiatrists and other clinicians. The spectrum of psychiatric illness seen in the general hospital units is more variegated than in mental hospitals. There is a wide range of psychiatric problems like neuroses, mood, organic brain and substance use disorders, in addition to psychoses.[2]

Consultation-liaison (CL) psychiatry has its roots in psychosomatic medicine, which is the study of 'mind-body' relationship. Investigators in psychosomatic medicine have historically been interested in the psychosomatic interface of medical patients, and were pioneers in the evolution of CL psychiatry.[3]

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Formal designation of consultation psychiatry and pedagogy is credited to George Henry, 1929.[4] CL psychiatry refers to the skills and knowledge utilized in evaluating and treating the emotional and behavioral conditions in patients referred from other health professionals.[3] It includes the study, practice and teaching of the relations between medical and psychiatric disorders.[4]

Currently in India, the CL psychiatry services mostly follow the consultation model. Psychiatrists evaluate the patients and advise the necessary management to the referring clinicians. There is hardly any liaison model, where psychiatrist is an integral part of the treating team and helps in the comprehensive management of the patients.[1,5,6]

Considering the high psychiatric morbidity in patients of other departments, there are few studies that focused on CL psychiatry. Available Indian studies reported low referral rates to psychiatry. Among inpatient referrals organic mental disorders was the common diagnosis found,[7,8] while it was 'neurotic, stress-related and somatoform disorders' among the outpatients.[9,10]

Referral patterns to psychiatry often ref ect the status of CL psychiatry in a hospital.

Methodology

The present study is a descriptive cross-sectional study, done in a 1000 bedded multi-specialty rural teaching hospital, catering to population of a district in southern Telangana. It includes all the patients referred to psychiatry from the other departments of the hospital, both outpatient and inpatient, between January 2013 to December 2015.

All the referred patients were subjected to a detailed examination including mental status assessment and the diagnosis was made as per ICD-10 criteria (International Classif cation of Diseases - Classif cation of Mental and Behavioral Disorders).

Socio-demographic features and prof le of referrals consisting of source, reason, time and nature of referrals were recorded in a proforma. History and clinical details of the patients given by the referring department were perused. Obtained information is tabulated, analyzed and discussed.

Observations and results

A total of 680 patients were referred to psychiatry constituting 10.5% of the cases seen by psychiatry department during this period. Among them, 257 were outpatients (OP), 423 were inpatients (IP) and the referral rate is 0.18%. Referral rate is the number of cases referred to psychiatry / total number of patients attending the hospital during that period × 100 (Table 1).

Table.1 Referrals and referral rate

Total referrals	Out patients	In patients	Referral rate
680	257 (37.8%)	423 (62.2%)	0.18%

Socio-demographic features

The socio-demographic features are summarized in (Table 2). Most of the referrals were in the age group of 21-40 years (356, 52.4%), males (416, 60.7%), Hindu by religion (626, 92%) and residing in rural areas (524, 77.1%). Most of the patients were married (534, 78.5%), from nuclear families (575, 84.6%), literate (388, 57.1%), employed (416, 61.2%) and belong to lower socio-economic status (454, 66.8%).

Referral prof le

Source of referral

Of the 680 referrals, 515 (75.7%) were from the medicine and allied branches and 165 (24.3%) were from surgery and allied branches. Highest number of referrals were from general medicine department 447 (65.7%). Department wise distribution of patients is in Table 3.

Reason for referral

On analysis of the reasons for referral, most common reason was evaluation of abnormal behavior 186 (24.2%), followed by medically

Table 2: Socio-demographic features

Characteristics	N = 680	Percentage
Age (in years)		
0 - 20	101	14.8
20 - 40	356	52.4
40 - 65	198	29.1
> 65	25	3.7
Sex		
Male	413	60.7
Female	267	39.3
Religion		
Hindu	626	92.0
Other religions	54	8.0
Residence		
Rural	524	77.1
Urban	156	22.9
Marital status		
Married	534	78.5
Unmarried	146	21.5
Type of family		
Nuclear	575	84.6
Joint	105	15.4
Education		
Illiterate	292	42.9
School	244	35.9
College	144	21.2
Occupation		
Employed	416	61.2
Unemployed	264	38.8
Socio-economic status		
Low	454	66.8
Middle	191	28.1
High	35	5.1

unexplained physical symptoms 130 (19.1%) and suicide attempt 103 (15.1%). Among inpatients it was evaluation of abnormal behavior 140 (33.1%) and in outpatients medically unexplained physical symptoms 84 (32.7%) (Table 4)

Time and nature of referral

Most of the referrals were day time referrals 585 (86%) and were routine referrals 522 (76.8%) (Table 5).

Psychiatric diagnosis

Of the 680 patients, 583 (85.7%) had a psychiatric diagnosis. The most common being substance use disorders 146 (2.5%) followed by 'neurotic, stress related and somatoform disorders' 124 (18.2%) and intentional self harm 91 (13.4%). Alcohol use disorders was the major chunk of the substance abuse with 138 patients (20.3%).

Most common diagnosis in the outpatients was 'neurotic, stress related and somatoform disorders' 84 (31.1%) followed by substance use disorders 31 (12.1%), while among the inpatient referrals it was substance use disorders 115 (27.2%) followed

by intentional self harm 82 (19.4%) (Table 6).

Nature of illness

After evaluation of 680 referred cases, 583 (85.7%) were diagnosed with psychiatric illness and 97 (14.3%) without any psychiatric illness. Co-morbidity of psychiatric and physical illness was found in 336 (49.4%) patients. Only psychiatric illness was found in 247 (36.3%) patients while 60 (8.8%) had only physical ailments. No illness was found in 37 (5.5%) patients (Table7).

Discussion

Previous Indian studies reported higher prevalence of psychiatric morbidity among the patients screened in the non-psychiatric areas of the hospitals and a low referral rate to psychiatry ranging between 0.15% - 3.6%.[1] Bhogale et al[9] reported 0.53% and 0.89% was reported by Manabendra et al.[11] These are very low when compared to higher rates of 2.2% to 12% reported from western countries[12], where CL psychiatry occupies a subspecialty status. A referral rate of 0.18% in the present study is very low by any standards. Probably the reasons for low referral rates in our country could be due to low awareness of psychiatric conditions among the clinicians along with their personal attitudes and issues of acceptance of psychiatry.

Most of the referred patients in the present study are in the age group 21-40 years (52.4%) which is comparable to other Indian studies.[6,9] While many western studies[13] reported more number of geriatric referrals, the present study has only 3.7% of referrals from elder age group (Table 2). Bhogale et al[9] reported 3.3% in their study. The low referral rates among the elderly in our country could be due to factors like lack of awareness about geriatric conditions and preference of alternative systems of medicine for the management of the elderly. In our country people take the geriatric problems in their stride and accept them with a philosophical fortitude.

In the present study 37.8% of referrals were from outpatient and 62.2% from inpatient services (Table 1). General Medicine department accounted for the highest number (65.7%) of referrals (Table 3). Bhogale et al[9] reported 45% outpatient and 55% in patient referrals with highest number (58.9%) from general medicine department. Manabendra et al[11] reported 86.4% of the referrals from General Medicine department.

Table 3: Source of referral

	OP n = 257	IP n = 423	Total N = 680	
General medicine	172 (66.9%)	275 (65.0%)	447 (65.7%)	
Paediatrics	13 (5.1%)	15 (3.6%)	28 (4.1%)	Medicine and allied branches 515 (75.7%)
Pulmonology	1 (0.4%)	11 (2.6%)	12 (1.8%)	
DVL	16 (6.2%)	4 (0.9%)	20 (3.0%)	
EMD	2 (0.8%)	5 (1.2%)	7 (1.0%)	
Anaesthesia	0	1 (0.2%)	1 (0.1%)	
General surgery	12 (4.6%)	39 (9.2%)	51 (7.5%)	Surgery and allied branches 165 (24.3%)
Orthopaedics	9 (3.5%)	41 (9.7%)	50 (7.4%)	
ENT	13 (5.1%)	4 (0.9%)	17 (2.5%)	
Ophthalmology	8 (3.1%)	3 (0.7%)	11 (1.6%)	
OBG	9 (3.5%)	25 (5.9%)	34 (5.0%)	
Dental	2 (0.8%)	0	2 (0.3%)	

Table 4: Reason for referral

	OP n = 257	IP n = 423	Total N = 680
Suicide attempt	13 (5.1%)	90 (21.3%)	103 (15.1%)
Abnormal behavior	46 (17.9%)	140 (33.1%)	186 (24.2%)
Medically unexplained physical symptoms	84 (32.7%)	46 (10.9%)	130 (19.1%)
History of substance use	22 (8.6%)	77 (18.2%)	99 (14.6%)
Depressive symptoms	9 (3.5%)	10 (2.4%)	19 (2.8%)
Anxiety symptoms	42 (16.3%)	20 (4.7%)	62 (9.1%)
Memory problems	3 (1.2%)	4 (0.9%)	7 (1.0%)
Decreased intelligence	8 (3.1%)	6 (1.4%)	14 (2.1%)
Sleep disturbances	8 (3.1%)	5 (1.2%)	13 (1.9%)
Sexual problems	10 (3.9%)	1 (0.2%)	11 (1.6%)
Past psychiatric illness – opinion regarding	4 (1.5%)	17 (4.0%)	21 (3.1%)
No specif c and clear reason	8 (3.1%)	7 (1.7%)	15 (2.2%)

Table 5 : Time and nature of referral

Time of referral	OP n = 257	IP n = 423	Total N = 680
Day	257 (100%)	328 (77.5%)	585 (86%)
Night	0	95 (22.5%)	95 (14%)
Nature of referral			
Routine	225 (87.5%)	297 (70.2%)	522 (76.8%)
Urgent	32 (12.5%)	126 (29.8%)	158 (23.2%)

Table 6 : Psychiatric diagnosis

Psychiatric diagnosis (ICD - 10)	OP n = 257	IP n = 423	Total N = 680
Organic mental disorders	8 (3.1%)	63 (14.9%)	71 (10.4%)
Substance use disorders	31 (12.1%)	115(27.2%)	146 (21.5%)
Psychotic disorders	20 (7.8%)	21 (5.0%)	41 (6.0%)
Mood disorders	28 (10.9%)	27 (6.4%)	55 (8.1%)
Neurotic, stress related and somatoform disorders	80 (31.1%)	44 (10.4%)	124 (18.2%)
Behavioral syndromes associated with physiological	12 (4.7%)	8 (1.9%)	20 (2.9%)
disturbances and physical factors			
Adult personality disorders	2 (0.8%)	0	2 (0.3%)
Mental retardation	14 (5.5%)	11 (2.6%)	25 (3.7%)
Childhood behavioral and emotional disorders	5 (1.9%)	3 (0.7%)	8 (1.2%)
Intentional self harm	7 (2.7%)	84 (19.8%)	91 (13.4%)
Nil psychiatry	50 (19.4%)	47 (11.1%)	97 (14.3%)

Table 7: Nature of the illness

Nature of illness	OP n = 257	IP n = 423	Total N = 680
Co-morbid illness	29 (11.3%)	307 (72.6%)	336 (49.4%)
Only psychiatric illness	178 (69.3%)	69 (16.3%)	247 (36.3%)
Only physical illness	16 (6.2%)	44 (10.4%)	60 (8.8%)
No illness	34 (13.2%)	3 (0.7%)	37 (5.5%)

People, ignorant and unmindful of other co-morbidities, usually seek general medicine consultation for their ailments. Most of the patients with substance use and all the patients with suicide attempt are stabilized in general medicine, before referral to psychiatry.

Referrals from general surgery and allied branches (24.3%) in this study (Table 3) is comparable to 14 to 28% reported in the other Indian studies.[8,14] Preoccupied with the surgical remedies, surgeons are likely to overlook the psychiatric symptoms in their patients, which explains the low referral rates from surgical departments.

Abnormal behavior (24.2%) followed by medically unexplained physical symptoms (19.1%) and suicide attempt (15.1%) are the most common reasons for referral in the present study (Table 4). Agitation, confusion, disorientation, hallucinatory behavior and restlessness are often perceived as abnormal and suicidal attempt a psychiatric emergency. Vague somatic symptoms, usually denote an underlying psychiatric illness, and hence the referral to psychiatry.

Among the inpatients abnormal behavior (33.1%), and in outpatients medically unexplained physical symptoms (32.7%) are on the top. Bhogale et al[9] and Manabendra et al[11] also reported the same reasons for referral as the most common.

Most of the referrals were in day time (86%) and routine in nature (76.4%). All the night time calls and most of the urgent referrals were from inpatient departments (Table 5).

Most common diagnosis of the referred patients in this study was substance use disorders (2 .5%) followed by 'neurotic, stress related and somatoform disorders' (18.2%) (Table 6). High prevalence of alcohol use in the district, availability of a de-addiction centre in the hospital and the expertise of clinicians in identifying the substance abusers are the factors contributing to more referrals in this diagnostic category. In their studies, Bhogale et al[9] and Singh et al[15] reported substance use disorders only next to 'neurotic, stress related and somatoform disorders', and mood disorders.

Other notable observations of this study are:

a) Among outpatients, most of the cases referred for evaluation of medically unexplained physical complaints were diagnosed with 'neurotic, stress related and somatoform disorders'. Among inpatients, most of the cases referred with abnormal behavior carried the diagnosis of organic mental disorders followed by substance use disorders.

b) Of the 103 (15.1%) patients referred for evaluation of suicide attempt, only 12 had depression and in the remaining 91 (13.4%) diagnosis was intentional self harm, where suicidal attempt is impulsive (Table 6). Most common mode of suicide attempt was consumption of organo-phosphorous compounds.

Presence of psychiatric morbidity in 85.7% of the referred patients, speaks well of the clinical competence of the referring doctors in identifying the obviously overt psychiatric symptoms. However, abilities to spot the sub-threshold symptoms will certainly improve the referral rates to psychiatry.

Co-morbidity of psychiatric and physical illness in 49.4% of the cases underscores the need for

improving consultation liaison services in the hospital (Table 7).

Conclusion

Very low referral rate in the present study, as elsewhere in India, ref ects the general trend of downplaying psychiatric co-morbidity in our country. Reasons could be issues of awareness and acceptance of psychiatry among the health professionals, and still prevalent stigma and superstition in rural areas. At times personal attitudes and apathy also play a major role.

As there is no health without mental health, the need of the hour is to improve psychiatric services in the general hospitals, possible only when CL psychiatry is practiced in word and spirit.

More of academic and interactive exercises between clinicians and psychiatrists, will result in increased awareness and acceptability of psychiatry.

Structuring the postgraduate teaching and training, with emphasis on consultation-liaison models, will improve the clinical milieu in the hospitals and paves the way for CL psychiatry to become a subspecialty in future.

Proactively revamping the undergraduate curriculum with an early exposure to psychiatry, by horizontal integration, helps to enrich the psychiatric awareness and orientation. Armed with a mindset of positive attitude towards psychiatry, budding doctors can play a key role in future, to promote CL psychiatry as a part of comprehensive health care.

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