

Practice and Pattern of Psychiatry referrals in a tertiary care teaching hospital

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ABSTRACT

The aim of the present study was to assess the pattern of psychiatric referrals from the different disciplines including Medical and Surgical emergency to assess the symptomatology, concordance rate of diagnosis between psychiatrist and non-psychiatrist, season and timing of the referrals at the tertiary care hospital, prospectively. Total number of patients who attended emergency room services and were admitted in different wards of the hospital during one year period was 64,204. Out of these 647 (1.01%) patients were referred for psychiatric consultation. More number of patients were referred in autumn season (29%), from Emergency Medicine (64.1%) and during evening hours. The most common reason(s) for which psychiatry opinion was sought in the decreasing order were Substance use(17.6%), Irrelevant talk(9.2%), sadness of mood (9.1%), pain/numbness(8.8%), previous psychiatry treatment (8.5%), fits(6.8%). Non-psychiatrist started treatment in 11% of patients whereas majority of the patients (>80%) needed treatment. In addition, in majority of the patients, in whom non-psychiatrist started treatment, prescription was changed by psychiatrist either because of inadequate dose or inappropriate medicines.

Key words: Psychiatry referral, referral practices

INTRODUCTION

Physical symptoms, which cannot be understood on the basis of known medical disorders and/or which are disproportional to the severity of medical illness, are frequent reasons for referring patients to mental health professionals. The increase in awareness and acceptance that medical and psychiatric problems coexist has led to a revival of interest in psychiatry units of general hospitals. Studies in the West have reported a very high percentage of psychiatric morbidity in medical outpatients ranging from 30% to 83%^{1 2}. An Indian study has also reported high prevalence rate of psychiatric disorders in medical out-patients ranging between 33.4% and 50%.³

There have been a number of reports of psychiatric referrals in a general hospital^{4, 5, 6}. The essential task in the emergency room is to provide effective and immediate intervention to patients. As compared to emergency room, there is more time to do a thorough check-up in medical and surgical wards, as well as to then provide appropriate services that include referral to other departments. Awareness of referring physician about the psychiatric symptoms becomes important determinant in the emergency for early identification, treatment and referral of patients suffering from mental disorders.

In India several authors have studied the rate of psychiatric referral in out-patient as well as in-patient population which varies from 0.06-2.64% and 0.15%-2.64% respectively⁷⁻¹². However, the

literature is very scanty about the symptomatology of psychiatric patients attending different disciplines of general hospitals. The specific information regarding pattern of referral in terms of season of the year and the time of the day is also inadequate. Also there is hardly any information about the skills and knowledge of the non-psychiatrists to identify and manage the psychiatric symptoms in medical patients by making probable psychiatric diagnosis and initiating the appropriate treatment on their own. Such study will be helpful in the understanding of knowledge and the attitude of the medical colleagues towards the specialty and services delivery by the psychiatrists and also planning the psychiatry training of the medical undergraduates, the doctors of tomorrow.

The present study was carried out with the following aims.

1. To study the overall rate of psychiatric comorbidity in patients attending non-psychiatric services.
2. To study the pattern and reasons of referrals.
3. To study the concordance of diagnosis by the referring physician and psychiatrist.

METHODOLOGY

A prospective study was carried out on consecutive patients referred from the different departments including general emergency OPD and different inpatients services of Government Medical College & Hospital (GMCH), Chandigarh, from 1st September, 2003 to August 31st, 2004. GMCH is a tertiary care hospital and caters to patients from Chandigarh, Jammu & Kashmir, Himachal Pradesh, Punjab, Haryana, Uttar Pradesh and Uttranchal.

A Senior Resident evaluated all the patients who were referred for psychiatric consultation. Diagnoses were made as per ICD-10 criteria¹³. The socio-demographic and clinical variables were recorded on a semi-structured walk-in-proforma.

This proforma is routinely used in the outpatient services of the department for brief assessment and recording diagnosis and management.

The data were analyzed using the Jandel Sigma-stat version 2 statistical software.¹⁴ Data has been described in terms of frequency (percentage) and chi-square with Yates correction.

RESULTS

A total of 62,204 numbers of patients, attended emergency room services or were admitted in different wards (other than psychiatry) of Government Medical College & Hospital during the above-mentioned period. Out of these, 647 (1.01%) patients were referred for psychiatric consultation.

The results of study show that young adults (age 21-40 years) constituted the majority (55%) of the referred population. The two extremes of age were represented equally i.e. above 50 years and below 20 years, and were both 15.8% of the total population. Males (51.9%) and females (48.1%) were almost equal.

Overall the maximum numbers of patients were referred in autumn (29%) from all the disciplines. In all seasons, maximum referrals were made from emergency medicine and pediatrics 65.9% (427). In comparison to this only 5.87% (38) referrals came from Emergency surgery OPD. Referrals were maximum during summers from both medical (32% of 97 referrals) and surgical wards (36.4% of 66 referrals) Although the patients were referred throughout the day for psychiatric opinion but the referrals increased sharply during evenings (40.3-46.1%) as compared to mornings (15.9-28.2%). The maximum number of referrals was seen in evenings in all seasons except during autumn, when night referrals were maximum (43%).

The most common reason(s) for which psychiatry opinion was sought, are shown in table

Table 1
Reasons of referral & Season

Reason(s)	Autumn (Sep-Nov)	Winter (Dec-Feb)	Spring (Mar-May)	Summer (Jun-Aug)	Total
Deliberate Self Harm	11	9	5	7	32(4.9%)
Depression	18	14	15	12	59(9.1%)
Substance Use	33	17	27	37	114 (17.6%)
Psychotic symptoms (Suspiciousness/Violence/agitation/ Irrelevant talk)	24	29	22	25	100 (15.3%)
Anxiety (Ghabhrahahat/palpitation)	11	10	4	8	33 (5.1%)
Conversion symptoms (Unresponsiveness/ Hyperventilation/Fits)	27	25	28	16	96(14.8%)
Somatic symptoms (Pain/numbness/ Weakness)	23	20	24	23	90(13.9%)
Others (Disorientation/ Fussy Patient Previous Psychiatric Treatment/ Others/ no specific reason)	41	25	31	26	123(19 %)

χ^2 22.132, p value 0.392

no.1. However, in some of the patients there was more than one reason for referral.

In 261 patients, referring doctor could not make any diagnosis. Psychosis/Mania, Depression and anxiety disorders were grossly under diagnosed, whereas functional (conversion) disorders were over diagnosed. (Table 2)

There was high concordance in the diagnosis of substance use disorders between the referring doctor and psychiatrist.

The diagnoses of referred cases as per ICD-10 were Neurotic, stress-related and somatoform disorder (25.8%), followed by Mood (affective) disorders (23.2%), Mental and behavioural disorders due to psychoactive substance use (19.6%), Organic, including symptomatic, mental disorders (9.7%), Schizophrenia, schizotypal and

Table 2
Comparative Diagnoses

Diagnosis	Psychiatrist No. of patients	Non- Psychiatrist No of patients
No Diagnosis	0	261
Psychotic Disorder(F20-29)	61	10
Manic episode (F31)	35	0
Affective disorders except manic episode(F30-39)	140	80
Neurotic disorders except F44 (F40-49)	118	29
Conversion disorder(F44)	49	105
Substance use disorders (F10-19)	127	120
Others	Nil	17

delusional disorders (9.4%), Epilepsy (2.3%), Behavioural syndrome associated with physiological disturbance and physical factors (2.16%), Others (1.7%) and Nil psychiatry (6%).

The referring doctor could start treatment on his/her own in just 11% of patients whereas majority of the patients (>80%) were not put on any treatment. The treatment initiated by referring physician was changed by psychiatrists in a large number of cases due to either inadequate dose or inappropriate medicine. (Table 3& 4)

Table 3

Treatment Prescribed by Non-psychiatrist

No medication	573 (88.5%)
Antipsychotics	17 (2.63%)
Antidepressant	5 (0.77%)
BDZs	52 (8.04%)

Table 4

Treatment started by Psychiatrist

Prescription	No. of Patients
No Change	25(3.8%)
Changed(Inadequate dose, inappropriate medicine etc)	49(7.5%)
Medicine started for the first time	466(72%)
Counselling	18(2.8%)
No active intervention	89(13.7%)

DISCUSSION

Out of 64,204 patients, 647 (1.02%) patients were referred for psychiatric consultation and out of them 641 (1%) were found to have diagnosable psychiatric disorder. In other studies, the referral rate varied from 0.5-10%^{6, 15-21}.

The slightly low rate of referral in our study may be because some of the patients might have been seen by the emergency medical officers and were not referred to psychiatric emergency services or may be advised to attend

the psychiatry OPD on next day.

Additionally, it has been observed that a large number of young patients were referred from the medicine emergency department for emotional disturbances and substance use disorder. It may be the result of increased awareness of emotional disturbances by the younger segment of the population. Some of these substance use disorder, neurotic and conversion disorder patients might have deliberately opted to attend the emergency services, to avoid the long morning queue of registration or to avoid treatment from psychiatry OPD services because of stigma attached to psychiatry.

The low referral rate from surgery department could be because the surgical patients have short pre-operative stay in the hospital and surgeons usually like to concentrate mainly on the physical aspect or only the organ where they have to operate. This is also in agreement with other studies.

The reason for more referral in evenings could be that the consultants take most of the decisions for referrals, when they come for the morning rounds in the wards. The senior residents are relatively free from their ward duty after 5pm, so they send the call late in the evening.

The most common reason(s) for referral were substance related problems (17.6%), irrelevant talk(9.2%), sadness of mood(9.1%), pain/ numbness(8.8%), previous psychiatric treatment (8.5%), fits(6.8%) and deliberate self harm(4.9%) and less common reasons were weakness, ghabhrahat/palpitation, hyperventilation, suspiciousness, disorientation and fussy patients. In 5.5% of referrals, no reason was mentioned.

In western studies^{5, 21} the most common reasons for referral were suicide attempt followed by the minor (neurotic) psychiatric symptoms, major (psychotic) symptoms and disturbing behavior. The difference in presenting symptoms

for which referral was sought could be due to different undergraduate training of medical officers, especially to elicit and identify the psychiatric symptoms, to assess the gravity of symptoms and need for psychiatric referral. Moreover, the earlier studies from India have reported that majority of the neurotic patients were handled by the physicians.^{23,24}

Although correlation of seasons with mental disorders have been highlighted in different studies,²⁵⁻²⁸ we have not found any strong correlation of referral with season except that slightly more cases of suicide attempt and sadness of mood were seen in autumn and slightly more referrals of substance related problems were reported in summer season.

In our study the most common diagnoses were Neurotic, stress-related and somatoform disorder (F 40-49, 25.8%), followed by Mood (affective) disorders (F 30-39, 23.2%), Mental and behavioural disorders due to psychoactive substance use (F 10-19, 19.6%), Organic, including symptomatic, mental disorders (F 00-09, 9.7%), Schizophrenia, schizotypal and delusional disorders (F 20-29, 9.4%). Our findings are slightly different from the findings of western studies with regards to the personality disorders.

In the study from western countries, common diagnoses were depression, organic disorders, hysteria and personality disorders⁵ The possible reasons could be that, the non-psychiatrists especially at the emergency services can handle some of the milder cases. This has been reported by other studies from India^{23,24,28}. We did not evaluate personality disorders because of assessment difficulties in the 'hectic and charged' atmosphere of the emergency room and also the symptom specific complaints by the referring doctor and relative in the wards and sometimes the non-availability of reliable informants among the accompanying relatives.

A significant percentage (6%) did not have

any psychiatric problem and these patients were predominately referred from emergency. This may be due to the tendency of the physicians posted in the emergency OPD to prematurely 'dichotomize' patients into "medical" or "psychiatric" based on inadequate clinical history or examination.

In this study the referring doctor did not make any diagnosis in 261(40.34%), and also under diagnosed the anxiety disorder, depression and psychosis and over-diagnosed the functional disorder. In a study from India, the tentative diagnosis was made by the referring unit in 50% of referred cases and a half of these were correct.¹⁰

In this study, the referring doctor did not start any treatment in more than 88% of cases, whereas more than 80% of patients needed treatment and majority of them had the common psychiatric disorders and substance related problems. It might be possible that psychiatry senior resident and junior resident is available round the clock and attended the call immediately and thus the referring doctor left it to them to make the diagnosis and start the treatment. Thus, referring doctor started the treatment in 11% (74) of patients only and subsequently the psychiatrist changed the treatment in 49 (66%) of these patients either because of inappropriate medicine, inadequate dose or overall incomplete prescription.

The findings reflect the overall deficient training in psychiatry and inadequate orientation to psychiatric problems among the non-psychiatrist referring doctors.

In majority of the general hospitals, the emergency medical officer attends the psychiatric emergencies. A large number of psychiatric disorders are missed because the attending physician does not have time for detailed assessment. Additionally, because of deficient undergraduate psychiatric training, he lacks skills necessary for clinical assessment of a psychiatric

patient. Other issues like limited space, lack of trained staff, ethics and confidentiality further limits the scope of intervention.

Since majority of the government hospitals either do not have adequate staff in psychiatry department or do not have psychiatry department especially at District level hospital, it would be worthwhile to train the medical officers in psychiatry for the identification and treatment of at least common mental disorders.

The development of comprehensive training programs for other health professionals including medical officers, nursing staff, resident doctors and other ancillary staff to handle the violent patients will inevitably lead to improvement in better psychiatric care of patients attending medical and surgical facilities. Limitation of present study was that personality disorders could not be diagnosed because of time constraint and non-availability of reliable informant.

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