

ORIGINAL RESEARCH

Profile of patients in consultation liaison psychiatry- An observational study at a tertiary care teaching hospital in North India

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ABSTRACT

Introduction: Psychiatry has come a long way and consultation liaison psychiatry (CLP) involving clinical understanding, teaching as well as research activities of psychiatry among the non-psychiatric divisions of a general hospital is expected to revolutionize the subject of psychiatry further. However, the amount of research in India is strikingly low in this regard. Study of referral patterns to psychiatry will help us identify the lacunae in the referral system in India and strengthen consultation liaison services. **Aim:** To study the referral pattern to psychiatry in a tertiary care teaching hospital. **Materials and Methods:** All inpatient referrals to the department of psychiatry for a period of four months were included in the study. Data was collected by a semi structured proforma. Psychiatric diagnosis was made with ICD 10 and descriptive statistics were applied. **Results:** The overall referral rate to psychiatry was found to be 1.8% with majority being from medicine. The most common reason for referral was suicidal attempts and most common psychiatric disorder diagnosed was mood disorders. **Conclusion:** An alarmingly low referral rate has been found consistently throughout studies despite high presence of psychiatric morbidities. There is an urgent need of better psychiatry training across different medical specialties. The need for enhancing the understanding of psychiatrists and special postgraduate training in this regard is also required.

Keywords: Referrals, Consultation-liaison psychiatry

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INTRODUCTION

Early part of 19th century witnessed the evolution of psychiatry as a distinct medical discipline from neurology. Despite innumerable challenges posed by stigma and superstition, this intriguing branch of medicine has come a long way. Many revolutions have been witnessed in the field of psychiatry beginning with unchaining and moral treatment of patients followed by advent of treatments like electroconvulsive therapy and antipsychotics permitting domiciliary treatment.¹ The treatment setups for patients with mental illness have changed from asylums, to mental institutes and finally to general hospital psychiatry units. The first General Hospital Psychiatry Unit (GHPU) in India was started at RG Kar Medical College and Hospital, Calcutta, India, in 1933². The number of GHPUs has

exponentially increased since resulting in the need for consultation and liaison with other departments.

Consultation Liaison Psychiatry (CLP) is a subspecialty of psychiatry that combines psychiatry with other disciplines, thus providing psychiatric education and care to non-psychiatric departments of a general hospital. 'Consultation' refers to the expert opinion provided at the request of a health professional of other discipline regarding patient's mental state and behaviour involving diagnosis as well as management strategies. 'Liaison' literally means effectual collaboration achieved by joining up of groups. Currently, the consultation-liaison services in India follow the consultation model, wherein a psychiatrist evaluates and manages the patient who is referred from a physician/surgeon³.

In India, despite high psychiatric comorbidities reported by the studies that have screened patients in

other departments (18.42%-53.7%), the referral rates have been found to be very low in most studies (0.06%-3.6)³. While western world has recognised consultation liaison as a subspeciality of psychiatry, there is a dearth of studies which have focused on consultation liaison psychiatry in India. With this background, a study of psychiatric referrals was conducted, with the objective of assessing the socio demographics of referred patients, source of referral, reason for referral and psychiatric diagnoses.

AIM

To study the pattern of referrals to the department of psychiatry.

MATERIALS AND METHODS

The study was an observational study conducted at a tertiary care teaching hospital in North India and included all consecutive referrals from inpatients of other departments to the psychiatry department within the 4-month study duration lasting from November 2022 to February 2023. Eligibility criteria included inpatient admitted to any department of the hospital other than psychiatry department and of either sex. No age limits were set. Outpatient-based referrals were excluded. 586 referrals were received, of which 23 patients absconded or left against medical advice before assessment could be done. During the course of

the study, 6 patients refused to participate. Hence, 557 patients were included in the study. All the referred patients were evaluated by a consultant psychiatrist and diagnosis was made according to the diagnostic guidelines, as per ICD-10 (International Statistical Classification of Diseases) – Classification of Mental and Behavioural Disorders⁴. Data obtained were analysed using descriptive statistical methods.

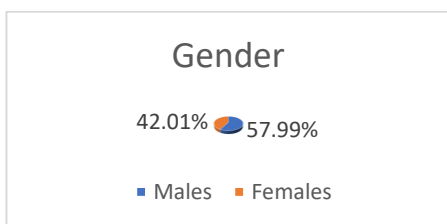
RESULTS

REFERRAL RATE

A total of 586 patients were referred for psychiatric consultation from various departments during the study period. Our hospital is a tertiary care teaching hospital with 6000 beds & observed 31,495 admissions during study period. The referral rate was found to be 1.8%.

SOCIODEMOGRAPHIC DISTRIBUTION

557 participants were included in the study out of which 323 (57.99%) were male and 234 (42.01%) were female. The mean age of the patients was 36.12 years, ranging from 6 to 87 years. The majority of the patients belonged to the 18–65 years age group (n=452, 81.15%). The number of patients in the age group below 18 years and above 65 years was 66 (11.85%) and 39 (7%), respectively.



Age group	Frequency (n)	Percentage (%)
0-18 years	66	11.85
18- 65 years	452	81.15
More than 65 years	39	7.00

SOURCES OF REFERRAL

Table shows the details of different sources (department wise) of psychiatric referrals. A majority of the referrals were made from the department of medicine (n=306, 54.93%). Other major sources of psychiatric referrals were departments of surgery (n=72, 12.92%), orthopaedics (n=55, 9.87%) and paediatrics (n=33, 5.93%).

Source of referral	Frequency (n)	Percentage (%)
Medicine	306	54.93
Surgery	72	12.92
Orthopaedics	55	9.87
Paediatrics	33	5.93
Obstetrics & Gynaecology	28	5.03
Chest & TB	44	7.90
Dermatology	5	0.90
ENT	10	1.80
Ophthalmology	4	0.72

REASONS FOR REFERRAL

Presents the various reasons for which referrals were called for. The most common reason for referral was alleged suicide attempt or self-harm (n=134, 24.06%) followed by having an abnormal behaviour (n=119, 21.36), followed by substance use (n=78, 14%).

Reason For Referral	Frequency (N)	Percentage (%)
Suicide / Self harm	134	24.06

Abnormal Behaviour	119	21.36
Disorientation	44	7.90
Substance use	78	14.0
Depression	27	4.85
Psychiatric history	55	9.88
Anxiety	11	1.98
Medically unexplained somatic symptoms	89	15.97

PSYCHIATRIC DIAGNOSES

The most common psychiatric diagnosis made was mood disorders (n=151, 27.10%) followed by neurotic, stress related and somatoform disorders (n=127, 22.8%), followed by substance use disorders (n=118, 21.18%).

Psychiatric Diagnosis	Frequency (N)	Percentage (%)
Neurotic, stress related & somatoform disorders	127	22.8
Mood (affective) disorders	151	27.10
Schizophrenia, schizotypal & delusional disorders	22	3.95
Organic mental disorders	39	7.01
Behavioural Syndromes associated with physiological disturbances & physical factors	11	1.98
Mental & Behavioural disorders due to psychoactive substance use	118	21.18
Others	28	5.03
Nil Psychiatric diagnosis	61	10.95

has not

been conclusive in this aspect. Some studies have shown a male preponderance^{7,12}, while others

DISCUSSION

This study was an attempt to recognize the pattern of psychiatric referrals in a tertiary care teaching hospital in north India. The referral rate was 1.8%. Referral rates in India have ranged between 0.06 to 3.6%³. Studies as early as 1998 have shown the referral rate to be 0.65% with 45% of referrals from medical specialities and 22% from surgical specialities. Some of the studies which had shown higher referral rates had looked into only a particular subset of patient population like emergency patients^{6,7} and cardiology outpatients⁵.

Despite the high psychiatric comorbidity in medical and surgical patients^{8,9}, the referral rate to psychiatry has been low. In order to understand the reasons behind the low rate of referral, non-psychiatric clinicians were assessed in a study about their referral to psychiatry¹⁰. Majority of those assessed felt that less than 20% of their patients had psychiatric problems and of these only 25% were sent for psychiatric referral. In the same study it was seen that about two thirds of clinicians referred their patients if they felt they would benefit from them, however 29% referred only when patients were over complaining. On being asked about their patients' response to psychiatry referral, half of the treating physicians felt that though the patients agreed, they didn't always keep the psychiatrist's appointment; whereas the other half felt that the patients agreed reluctantly. Some studies have shown that, of the patients referred to psychiatry, 93.7% actually went for the review which led the authors to conclude that the systemic and referrer factors played a major role rather than the patient factors^{11,12}.

There was preponderance of males in referrals (57.99% vs. 42.01%). The data from previous studies

have reported that female referrals were more common than male referrals^{13,14}.

The majority of referrals were in the 18–65 years age range (81.15%), with a mean age of 36.12 years. This observation is consistent with the findings of other studies^{15,16}. The proportion of the referred patients in the age group of more than 65 years was 7%. This was in accordance to the findings of other Indian studies¹⁰. In contrast, western data suggest that the percentage of referrals in this age group is quite high¹⁷. This could be due to various local factors like a lesser life expectancy¹⁸, a lack of awareness about geriatric conditions like dementia¹⁹, preference of alternative systems of medicine like ayurveda, homeopathy and unani and family neglect. Also, Indian families have a tendency to accept geriatric problems as age related and normal.

When the sources of referrals were analyzed, it was found that a majority of the patients were referred from the department of medicine. This was in agreement with findings of previous studies which have shown that 54.3% to 64.78% of patients were referred from department of medicine^{15,16,10,11}. The somatic symptoms of various psychiatric illnesses are given more importance in Indian culture. Therefore, inadvertently the patients visit general physicians for the treatment of their physical symptoms. Ignorance about the psychiatric origin of somatic symptoms and the stigma which is associated with psychiatric consultations are other factors which may result in patients visiting physicians instead of psychiatrists.

When reasons for referrals were analysed, suicide/self-harm (24.06%) topped the list, followed by abnormal

behaviour (21.36%). This finding is inconsistent with a study²⁰ where it was ascertained that altered level of consciousness and aberrant behaviour along with psychosis-related behaviour were the leading reasons for referral representing 31.9%. Another study¹⁵ found self-harm to be the second leading cause while yet another²¹ found abnormal behaviour to be the most common cause at 30.9%. This finding in our study can be attributed to the fact that most cases of abnormal behaviour present among admitted patients are either not recognised or not referred to psychiatric services by general physicians/ surgeons as such cases are not evaluated for psychopathology with the same enthusiasm as for medical symptoms. Hence, only when agitation or abnormal behaviour gets beyond the threshold of the managing staff, a psychiatric consultation becomes prudent in such cases. On the other hand, there are medicolegal implications involved with cases of suicidal behaviour and self-harm. This invariably leads to psychiatric referral in almost all cases admitted for the same.

Third leading cause was medically unexplained somatic complaints accounting for 15.97% of the total referrals. Surprisingly, this number was lesser than previous studies which reported high prevalence of functional somatic symptoms in Indian patients who have psychiatric illnesses²² & high number of referrals for same. Reason for this could be stigma regarding mental health- among patients, physicians and nursing staff, resulting in either no referral at all or refusal by patient for psychiatric referral. Substance use was the reason for 14% of the total referrals. This was similar to the findings of a study²³ which showed that 14.5% of the referrals were caused by substance use. In contrast, another study²⁴ showed that a lower percentage (2-5%) of patients were referred for substance use, which the authors attributed to a lack of affordability.

Psychiatric diagnoses of the inpatient referrals showed mood (affective) disorders to be the most common psychiatric disorder, followed by Neurotic, stress related & somatoform disorders and substance use disorder. These findings corroborate with other studies^{22,23}.

Some studies from India^{25,26} and a review of CLP in China¹³ suggest organic mental disorders to be the leading factor in psychiatric diagnosis. However, the relative lack of organic mental disorders (7.01%), similar to the findings of other Indian studies^{27,28} could be attributed to the presence of trained neurology specialists at our hospital who are more accessible for physicians, in turn leading to fewer referrals of such cases.

Interestingly, no psychiatric diagnosis was made in a significant 10.95% of the referred patients. The reasons for referral in these patients were medically unexplained somatic complaints, headache, anxiety and episodes of loss of consciousness. This group represented the 'false-positive' cases which were referred by doctors, possibly due to various factors

like non-response to conventional treatment and abnormal illness behaviour, accidental poisoning, agitation and insomnia secondary to pain and language barrier misconstrued as irrelevant talks. This also signifies a relative lack in understanding of psychiatric symptomatology by other disciplines. There is definitely a need to sensitise other medical specialities regarding identification of psychiatric comorbidities.

CONCLUSION

Consultation liaison is a developing branch in India that needs more attention. In accordance with earlier studies, it has been demonstrated that there are very few psychiatry referrals and an alarmingly low referral rate, in proportion to the psychiatric morbidities in medical setting. One cannot turn a blind eye towards psychiatric morbidities in these patients as this leads to a significant functional impairment, prolonged hospitalisation and increased health costs. It is well known that psychiatrists are now equipped with safe and effective psychotropic medications and other non-invasive brain stimulation techniques as well as evidence based psychosocial treatments. It is the underutilization of these services by medical specialities that is the roadblock. The stakeholders involved are required to work at this front and solve this problem. We suggest that psychiatry training should be given more weightage in the undergraduate medical curriculum and that more liaison activities such as regular interdepartmental meets, case conferences and seminars should be organised between psychiatry and other disciplines, so that a better understanding of psychiatric symptomatology, early symptom recognition, swift referral and follow-up can be ensured, which would be key to improving CLP services. There is an urgent need to improve CLP services and training to provide the best and optimal care to patients and to cater the best education to the medical staff. Patients suffering from almost all types of medical or surgical illnesses were also referred for some or other behavioural complaints. Most of the existing literature published in relation to CLP services has been inexplicit with regard to functional aspect and ways of improving services. Further research is warranted, especially longitudinal studies on outcome variables with respect to various clinical processes, such as interviews, length of visits and follow-up activities. In addition, future studies need to assess the knowledge and attitudes of patients, families and healthcare providers regarding mental illness, C-L (- Consultation- Liaison) service, barriers and so on. The findings from such assessments will help with cultural and organisational changes to better integrate C-L service into a general hospital.

LIMITATIONS

Despite all the efforts and inputs, there are few limitations to our study which should be considered while interpreting the results, such as the use of purposive sampling, the study's limited duration, lack

of follow-up, not longitudinal in nature and reliance on patient report without supporting methods like inter departmental liaison, joint rounds, case conferences. Hence the results cannot be generalised to all settings.

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