

A CLINICAL AUDIT OF REFERRALS TO THE PSYCHIATRY DEPARTMENT FROM OTHER SPECIALTIES: A STUDY FROM CENTRAL INDIAAjagallay R. K¹, Das S², Salankar H³, R. Chanchlani⁴**HOW TO CITE THIS ARTICLE:**

Ajagallay R. K, Das S, Salankar H, R. Chanchlani. "A Clinical Audit of Referrals to the Psychiatry Department from other Specialties: A Study from Central India". Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 13, March 31; Page: 3401-3407, DOI: 10.14260/jemds/2014/2297

ABSTRACT: INTRODUCTION: The rate of psychiatric referrals is reported to be high in hospitalized patients in different studies in developing countries. A high prevalence rate of psychiatric disorders is reported among many outpatient departments. For the quality and effectiveness of the various healthcare services, the active role of the psychiatric services in a general hospital cannot be neglected. **OBJECTIVE:** To evaluate the pattern of psychiatric referrals from various specialities and to study different psychological conditions affecting physical disorders. **MATERIAL AND METHODS:** The study was conducted at Chirayu medical college and hospital over a period of one year. It was a retrospective evaluation based study. There were 215 referrals recorded, inclusive of inpatient referrals only and diagnosis was made based on ICD-10 classification. **RESULTS:** Among the 215 referrals, age range of the subjects was 5-75 years with a mean age of 47±12 years. The most common reasons for referral were disorientation and altered sensorium (34%) followed by irrelevant talks (32%). The most common psychiatric diagnosis made was delirium (30.6%) followed by psychotic spectrum disorders (11.6%). Department wise referrals were mostly from medical units (40%) followed by surgical units (11%). No psychiatric diagnosis was made in 42 cases (20%). **CONCLUSION:** Early diagnosis and intervention of psychiatric disorders in those having physical illnesses definitely hastens recovery and reduces morbidity and the period of stay at a hospital. **KEYWORDS:** Consultation liaison psychiatry, Co-morbidities, Psychiatric referrals.

INTRODUCTION: Liaison psychiatry specializes in bridging psychiatric services to other specialities and it has been actively intervening in prevention of the communication gaps between the various specialities in many health care setups and thereby providing them the ability to convey understanding of the complexity in treating patients with physical and psychiatric co-morbidities. Quality of health care is strongly influenced by efficient communication between different levels of care. So, consultation liaison psychiatric services can be regarded as a linchpin between psychiatry and the other medical specialities.

The psychiatric evaluation facilitates case identification, as well the needful intervention on abnormal behaviors, thus lowering the duration of stay at a hospital, re-admission, morbidity and burden to the patient's family and global costs. For the quality and effectiveness of the various healthcare services, the active role of the psychiatric services in a general hospital cannot be neglected.

The rate of psychiatric referrals is reported to be high in hospitalized patients in different studies in developing countries.¹⁻³ In addition to these studies high prevalence rates of psychiatric disorders is reported among many outpatient departments.^{4,5}

The incidence of mental disorders in hospitalized physically ill patients ranges from 5.0% to 50%.⁶ A survey of two developing towns in western Nepal in 1998 revealed a high point prevalence

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(35.0%) of conspicuous psychiatric morbidity.⁷ Lifetime prevalence of mental disorder in chronically physically ill patients is around 42% compared to 33.0% who did not have long term physical disability.⁸ Psychiatric morbidity is associated with high utilization of general medical services and compromises patient's functional status and quality of life. Consultation liaison psychiatry enhances the quality of care of medical and surgical patients.⁹

Both biological as well as psychological factors should be considered in making diagnosis, treatment and prevention of diseases.¹⁰ The association between physical factors and emotional reactions to them are substantially implicated in various symptomatology of physical illnesses.¹¹ The objective of our study was planned to audit the frequency and pattern of referrals along with many other outcomes as described below.

MATERIAL AND METHODS:

Study Design: Record based retrospective study.

Sample Size: The data of all 215 patients referred to the psychiatry department over a period of one year was reviewed and analyzed.

Inclusion Criteria: Only inpatients records were included in the study.

Study Setting: Department of Psychiatry, Chirayu medical college and hospital, Bhopal.

Study Duration: One year (from September 2012 to August 2013).

Study Tool: Pretested and predesigned structured proforma was used.

It consisted following parameters like Socio-demographic variables, presenting complaints, underlying co-morbid physical diagnosis, provisional psychiatric diagnosis, time of referral since admission, treatment advised and response on follow up after one week.

Ethical Clearance: Permission was taken from Institutional Ethical committee.

Data Analysis: Data were entered and analyzed using Microsoft Excel 2007.

RESULTS: Among the 215 referrals, age range of the subjects was 5-75 years with a mean age of 47 ± 12 years. Patients belonging to rural areas were 81% while 19% belonged to urban areas. Among these, 56.7% were females and 43.2% were males.

Department wise referral was mostly from medical units 40% followed by 11% from surgical units, 9% from each of orthopedics and TB & chest disease, 8% each from obstetrics/gynecology and ICU setups. Distribution of patients according to the referrals from various departments is shown in table no. 1.

The most common presenting complaint was disorientation and altered sensorium as observed in 34% patients followed by irrelevant talks 32%, agitation/violent behavior 30% and 16% of them had decreased sleep.

The cases of poisoning outnumbered most of the physical diagnosis as they were 26% followed by postoperative cases 19%. Distribution of patients according to the clinical diagnosis is shown in table no. 2.

The time of referral since hospitalization was maximum after 48 hrs. in 42.7% followed by 30% during 24-48 hrs. and 27% were referred during the initial 24 hrs. which indicates that as the duration of stay at a ward increased, the psychiatric symptoms frequently get manifested.

Out of 215 referrals, provisional psychiatric diagnosis was made according to ICD-10 in 173(80%) of the patients and no psychiatric diagnosis in 42(20%) cases. The most common diagnosis made was delirium 30.6% while psychotic spectrum disorders comprised 11.6% followed

by mild cognitive disorder 9.76%. Distribution of patients according to the provisional psychiatric diagnosis is shown in table no. 3.

Out of 173 patients diagnosed with a psychiatric diagnosis, about 108 patients (62.4%) were advised psychotropic medications while 65(37.6%) cases were already prescribed psychotropic medication by their respective departments. The various medications prescribed by our side included antipsychotics to 54(50%) of the cases followed by anxiolytics to 32(30%) of the subjects. Distribution of patients according to the medication prescribed is shown in table no. 4.

In addition to the above, follow up after one week was advised to the patients who received medications and out of them only 46 patients (43%) attended the outpatient department while 16 patients (15%) were referred again before one week due to either patient reluctant to take medications or adverse drug reactions like extra pyramidal symptoms or over sedation. Patients were evaluated clinically for any improvement on follow up and it was observed that out of 46 (43%) patients attending outpatient department, 30(65.2%) of them had shown improvement.

DISCUSSION: In our study, when the sources of referrals were analyzed, it was found that a majority 50% 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.^{11, 12, 13} This could be attributed to greater number of patients with psychiatric co-morbidities prefer to consult general physicians as many of the patients and their family members could not recognize psychiatry as a distinct specialty since long time or due to stigma associated with this specialty.

When the reasons for referral were analyzed, it was found that the most common presenting complaint was disorientation and altered sensorium as observed in 34% patients. As described above, the most common psychiatric diagnosis made was delirium (30.6%) and this is in agreement with findings of previous studies in which 10-30% cases were diagnosed as delirium.^{12, 14} As studies indicate that a high index of suspicion for delirium is needed as patients may experience myriad psychiatric symptoms.

As delirium is associated, declines in cognition, function, and behavioral control which can be addressed by correcting underlying conditions and responding to care needs with the help of an interdisciplinary team. The next common diagnosis was psychotic spectrum disorder which comprised of 11.6% which is higher than that observed in some of the studies where it ranged from 4-6%.¹⁵

Interestingly, no psychiatric diagnosis was made in a significant 20% of the referred patients. This is higher as compared to earlier studies.¹²

The time of referral since hospitalization was maximum after 48 hrs. (42.7%) of admission which is in accordance with previous studies.¹⁶ This is consistent with the higher number of patients diagnosed as delirium in our study as delirious patients frequently manifest behavioral symptoms and signs during early stage of the disorder.

The most common psychotropic medication prescribed in our study was antipsychotics (50%) followed by anxiolytics 30%. In antipsychotic drugs, haloperidol (55.5%) was the most common antipsychotic prescribed as higher number of patients belonged to cases of delirium. There are few controlled studies of these medications for delirium and no placebo-controlled randomized controlled trials (RCTs).^{17, 18} Haloperidol is recommended in clinical practice guidelines.¹⁹

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There were few limitations to this study. First, only inpatient referrals were included as it was difficult to maintain record of outpatient referrals due to lack of manpower and resources. Secondly, the study subjects were taken from one tertiary care, urban hospital, and these results may not generalize to other types of settings. This may be especially true since different hospitals are likely to use different consultation liaison psychiatric services.

CONCLUSION: The above observations show that early diagnosis and intervention of psychiatric disorders in those having physical illnesses definitely hastens recovery and reduces morbidity and the period of stay at a hospital thereby reducing the burden to the patient as well as their family members. In addition to the above, consultation liaison psychiatric services could improve overall implementation of proper utilization of health care services and it gives an opportunity to a psychiatrist to directly deal with the physically ill patient.

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Departments	Frequency (n)	Percentage (%)
General medicine	86	40
Cardiology	12	5.58
Intensive care units	18	8.37
Surgery	24	11.16
Paediatrics	10	4.65
Orthopedics	20	9.30
Obs/gynecology	18	8.37
TB & chest	20	9.30
Dermatology	6	2.79
Oncology	1	0.46

Table no. 1: Distribution of patients according to the referrals from various departments

Physical diagnosis	Frequency (n)	Percentage (%)
Poisoning	56	26.0
Seizure disorder	11	5.11
COPD	20	9.30
CVS disorder	12	5.58
Alcohol intoxication	8	3.72
Dementia	4	1.86
Encephalopathy	18	8.37
Malaria	10	4.65
Pulmonary tuberculosis	20	9.30
Burn	6	2.79
Post-partum psychosis	10	4.65
Post-operative cases	40	18.6

Table no. 2: Distribution of patients according to the clinical diagnosis

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Psychiatric diagnosis	Frequency(n)	Percentage (%)
Delirium	66	30.6
Dementia	4	1.86
Psychotic disorders	25	11.6
Mood disorders	12	5.58
Anxiety disorders	11	5.11
Non organic insomnia	16	7.44
Mild cognitive disorder	21	9.76
Post encephalitic syndrome	18	8.37
No psychiatric diagnosis	42	19.5

Table no. 3: Distribution of patients according to the provisional psychiatric diagnosis

Medications	Frequency (n=108)	Percentage (%)
Antipsychotics:		
Haloperidol	30	55.5
Risperidone	12	22.2
Olanzapine	10	18.5
Amisulpride	2	3.70
Anxiolytics:		
Clonazepam	10	31.2
Lorazepam	18	56.2
Oxazepam	2	6.25
Alprazolam	2	6.25
Mood stabilizers		
Sodium Valproate	10	66.6
Oxcarbazepine	05	33.3
Antidepressants:		
TCAs	3	42.8
SSRIs	3	42.8
SNRIs	1	14.2

Table no. 4: Distribution of patients according to the medication prescribed

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