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PATTERN OF PSYCHIATRIC REFERRALS IN A TERTIARY CARE PUBLIC SECTOR HOSPITAL OF KARACHI

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ABSTRACT

Objective: To observe the frequency and pattern of Psychiatric referrals by Emergency and In-patient Departments (IPD) of tertiary care public sector hospital of Karachi.

Methodology: A comparative cross-sectional study was conducted in the referred cases of Emergency (ER) and In-patient Department (IPD) for Psychiatric consultation from December 2019 to May 2020. The available medical records and International Classification of Diseases (ICD-10) diagnostic criteria were used for assessment and the record register was maintained on regular basis for data collection. The Data was analyzed to compare the findings in both ER and IPD.

Result: There was a total of 281 referrals recorded in the register during six months. Among those112 (39.9%) were made from ER while 169 (60.1%) were from IPD. Most of them were young (33.4±13.5 years) and were almost equally distributed in both genders [Male=141 (50.2%) and Female=140 (49.8%)]. Altered or disorganized behavior, 88 (31.3%) followed by unexplained somatic complaints, 36 (12.8%,) and past psychiatric history, 25 (8.9%) were the most frequent reason for a referral from IPD. Suicide and deliberate self-harm were more common in ER 12 (4.3%) than that in IPD 6 (2.1%).

Conclusion: Overall the frequency of Psychiatric referrals was low in comparison to the patient population and most of those were from the inpatient department than the ER.

Keywords: Emergency; Inpatient; Psychiatric; Referral; Consultation.

INTRODUCTION

Mental Health problems are prevalent in the community and even more frequent in the hospital population. World Health Organization has estimated the high burden of mental health problems all over the world, especially in middle and low-income countries. That burden rises further particularly when those are comorbid with chronic medical illnesses such as diabetes, and cardiovascular and systemic inflammatory diseases, which significantly complicates the prognosis and even increases mortality. Despite this fact, it has been established with evidence, that it is not only the general public but also the general health professionals who bear discriminatory attitudes towards psychiatric problems that ultimately result in either ignoring the care or mismanagement of those patients. Psychiatric patients or those with apparent behavioral and psychological disturbances even in a hospital setting are neglected in various ways. Generally, they face difficulties by misdiagnosing, mislabeling, and compromising their care or by referring them to psychiatry without proper communication of information to them and psychiatrists.[1,2]

The available research work in neighboring countries like India revealed certain significant findings related to Psychiatric referrals in the hospitals; they had found very limited psychiatric referrals even in tertiary care setup. Only those cases were being referred who had either acute psychiatric presentation, made a suicidal attempt, or presented with a known psychiatric problem. Among those patients, 20-30% of cases were found to be misdiagnosed with psychiatric disorders and later on found to be suffering from Organic mental disorders instead. The neurotic, stress-related, or somatoform disorders (15-40%) were among the frequently diagnosed psychiatric morbidities in the general hospital population. Most of the departments including surgical, pediatric, and, various subspecialty units; Ophthalmology, and ENT do not usually refer their patients to the psychiatry department unless their behaviors become agitated or unmanageable with them. The highest referral cases had been reported from internal medicine and neurology departments.[3,4] The general problem that arises because of not making timely referrals is the undue economic burden on individual and public sector hospital resources. The poor identification and mismanagement of psycholog-

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ical problems are invariably common even in a pediatric group that significantly affects childhood developmental time.[5] There is usually no regular trend of Psychiatric consultations in general health settings of public sector hospitals in middle and low-income countries. Grover et al[6] studied the effects of two models for Psychiatric consultation and liaison work, a) consultation and b) hybrid. They found the hybrid model to be more effective where mental health professional was supposed to be placed full time in the general health setting to early identify psychosocial issues, collaborate with the other members of the team for timely, safe, and individualized interventions, and train them to be confident enough to practice mental health principles as an integrated segment of general health care. While in the consultation model mental health professionals will only provide services when referrals are sent to them for particular cases identified by non-mental health professionals for their specific reasons. However, the consultation model is somehow being practiced in developing countries like Pakistan because of poor localization of resources and a lack of acceptance of the importance of integrated mental health care with general health.

Primarily very limited work has been done in Pakistan in this area, however, Minhas et al work highlighted the importance of the inclusion of psychiatric consultation and liaison services in the general health setting.[7] Imam et al through their work identified a significant burden of undiagnosed common mental health problems especially depression in hospitalized medical patients due to inadequate skills in the health professionals, which ultimately complicates economic resources and overall disease prognosis.[8] Hence it is the intense demand of the current time, especially in lower and middle economic countries like Pakistan where there is a dearth of resources specifically to cater to mental health needs, to develop the already existing mental health services with manpower, infrastructure, and allocation of available resources by adequate budgeting. In public sector hospitals poor patients frequently visit ER because of two major reasons first due to poor resources; they avail health services only when necessarily required and secondly, poor awareness and lack of acceptance of mental health conditions their help-seeking is either delayed or happens only when they are being referred due to disruptive or strikingly unmanageable behavior. Therefore, besides the outpatient department, ER is also the major source for admitting patients and referring them to other facilities. This creates a burden of care and compromise in the delivery of appropriate services as per the patient's needs. Consequently, the known psychiatric patients are either being ignored in receiving physical care because they are directly referred to psychiatrists despite their visit for physical complaints or they are being taken for granted in giving care. The patients with acute behavioral disturbance and those with ambiguity in medical diagnosis are referred to psychiatrists without a complete medical assessment. There is also no system of exchange of information or collaborative communication for those cases. The patients who get admitted to other wards are also being discriminated against if they show altered behavior or their medical diagnosis could not establish. In our setup no work has been done in this area hence we lack in having general data that define the actual burden of the problem so that relevant constructive measures would be taken by forwarding it to higher authorities. This study aims to observe the frequency and compare the pattern of presentation of psychiatric referrals by both emergency and inpatient departments of a tertiary care public sector hospital in Karachi. It is intended to make mental health services an integrated part of each general health setting and also empower health professionals to work collaboratively to promote health holistically by managing both health aspects physical and psychological for better prognosis and outcome.

METHODOLOGY

This is a descriptive cross-sectional study that was conducted in the Psychiatry department of Dr. Ruth K.M. Pfau Civil Hospital Karachi for the period of six months from Dec 2019 to May 2020. The study was approved by the institutional review board [(IRB-1447/ DUHS/ Approval/2019/)]. The study Participants were the hospitalized patients referred for Psychiatric consultation from emergency and inpatient departments (medical, surgery, and allied wards where patients are admitted). They were selected through the non-probability consecutive type sampling technique; all cases included those who satisfied the set inclusion criteria.

The inclusion criteria were the patients of all ages and both male and female gender, referred from Emergency and other inpatient departments of the hospital having wards for admission facility. Those who have active psychiatric presentations, and were referred with proper referral request to the psychiatry department and given informed written consent

The Exclusion criteria included unadmitted or Outpatient and legal cases and those who were discharged or left against medical advice. Those who did not give consent or approached without proper referral were also excluded.

The Record register is the study instrument that has been used to document information related to those referred cases in the Psychiatry department. The register had sections for the following details referring department, reason of referral, patient's age, and gender, primary or working physical diagnosis, Psychiatric diagnosis, advised treatment, and outcome of consult.

After ethical approval from the institute, the Record register was being maintained on daily basis by the on-call psychiatry res-

ident. The residents were being trained by the principal investigator in the group for this task before the study. The register was being duly checked regularly for its completeness and authenticity. The patients were enrolled in the study after written informed consent. They were assessed by the on-call resident under the supervision of a consultant by taking detailed psychiatric history and mental state examination. The background details of the patient regarding the patient's primary or working diagnosis, the reason for admission, ongoing treatment, investigations, and a detailed account of the reason for referral were sought from the available record from the admission file or ER slip and the referring doctor as well. The collateral information from reliable and available attendants was taken regarding the premorbid functioning and personality, personal, family, and past psychiatric illness, any trauma, ongoing stressors, or substance use. The possible Psychiatric diagnosis was made on the International Classification of Diseases, ICD-10 criteria. The patient's management was prioritized as per the demand of their health condition i.e., providing or continuing medical or surgical care with added psychiatric care when required and offered to follow up for further psychiatric help.

The data was analyzed using Statistical Package for Social Sciences (SPSS) version 19. The mean and standard deviation were calculated for age. While the frequency was calculated for gender and Clinical details such as primary or working diagnosis, psychiatric diagnosis, advised treatment, and outcome of consult. Post-stratification, the Chi-square test was applied and a p-value of <0.05 was considered significant. The Emergency cases were analyzed separately to compare the findings of frequency and pattern of referral with that of Inpatient departments such as reason of referral, primary or working diagnosis, Psychiatric diagnosis, advised treatment, and outcome.

RESULTS

This study was conducted to observe the frequency and to compare the pattern of psychiatric referrals between ER and the Inpatient departments of the Public sector hospital, in Karachi. At the end of six months, a record of a total of 281 patients was maintained in the register. Regarding demographic details of the study sample; we found both Male and Female patient referrals were almost equal. Most of the patients were from the young age group with mean age of 33.4±13.5 years. The Frequency of referral of patients for psychiatric consultation was lesser in the emergency department (ER), (n=112, 39.9%) than in the inpatient department (n=169, 60.1%). While among inpatient departments the most frequent referrals were from internal medicine (n= 57, 20.3%) followed by surgery (n= 30, 10.7%), gynaecology & obstetrics (n=17, 6%), neurology (n=16, 5.7%), and trauma (n=15, 5.3) (Table 1).

Reason of referral included altered or disorganized behavior (n=88, 31.3%) followed by unexplained somatic complaints (n=36, 12.8%) in IPD while in ER, it was unexplained somatic complaints (n=42, 14.9 followed by altered or disorganized behavior (n=38, 13.5%). The Chi-square test was applied to observe the statistically significant difference (p <0.05) between the pattern of psychiatric referrals in ER and IPD. The difference was significant among reason of referral (p=0.001), primary diagnosis (p=<0.001) and psychiatric diagnosis (p=<0.001). In the majority of referrals, the given presentation either couldn't satisfy any psychiatric diagnosis [IPD n=58, 20.6% and ER (n=27, 9.6%)] or diagnose as delirium secondary to the underlying physical condition [IPD (n= 37, 13.2%) and ER (n= 9, 3.2%)]. (Table 2). In our study, most of the referred patients were managed with either non-pharmacological interventions (counseling, informational care, etc) [IPD (n= 43, 15.3%) and ER (n= 12, 3.9%)] or advised further observation and investigation till the clarification of diagnosis because the primary diagnosis was uncertain at the time of

Table 1: Descriptive characteristics of demographic and other study variables

Variables		n (%)
Gender	Male	141 (50.2)
	Female	140 (49.8)
Age (Years) 33.4±13.5	<18	19 (6.8)
	18-25	82 (29.2)
	26-40	113 (40)
	41-60	54 (19.2)
	>60	13 (4.6)
Referring Departments	Emergency	112 (39.9)
	Inpatient	169 (60.1)
	Medicine	57 (20.3)
	Surgery	30 (10.7)
	Neurology	16 (5.7)
	ICU (Surgery & Medicine)	6 (2.1)
	Dermatology	10 (3.6)
	Gynae/OBS	17 (6.0)
	ENT/Eye	1 (0.4)
	Burns	5 (1.8)
	Trauma	15 (5.3)
	Others	12 (4.3)

Table 2: Pattern of Psychiatric referral

Pattern of referral		IPD (n=169)	ER (n=112)	p-Value
		n (%)	n (%)	
Reason of Referral	Altered/ Disorganized Behaviour	88 (31.3)	38 (13.5)	0.001
	Known Psychiatric Problem	25 (8.9)	10 (3.6)	
	Substance Use Disorder	14 (5)	10 (3.6)	
	Suicidality/Deliberate Self Harm	6 (2.1)	12 (4.3)	
	Unexplained Somatic Complains	36 (12.8)	42 (14.9)	
Primary Diagnosis	Medical Disorder	59 (21)	20 (7.1)	<0.001
	Surgical Disorder	78 (27.8)	5 (1.8)	
	Neurological Disorder	8 (2.8)	5 (1.8)	
	Other (Undiagnosed/ Unexplained)	24 (8.5)	82 (29.2)	
Psychiatric diagnosis	Somatoform Disorder	3 (1.1)	13 (4.6)	<0.001
	Depressive Disorder	21 (7.5)	11 (3.9)	
	Bipolar Disorder	6 (2.1)	5 (1.8)	
	Psychosis (Acute Psychosis/Schizophrenia)	8 (2.8)	11 (3.9)	
	Delirium	37 (13.2)	9 (3.2)	
	Substance Use Disorder	12 (4.3)	14 (5)	
	Organic Brain Syndrome	17 (6)	12 (4.3)	
	Unestablished or Other	58 (20.6)	27 (9.6)	
	Anxiety or Stress Related Disorder	7 (2.5)	10 (3.6)	
Advised treatment	Antidepressants	20 (7.1)	4 (1.4)	0.12
	Antipsychotics	24 (8.5)	17 (6)	
	Benzodiazepines	41 (14.6)	6 (2.1)	
	Treat Primary Cause or Observation/ Investigation	6 (2.1)	29 (10.3)	
	Nonpharmacological Intervention	43 (15.3)	11 (3.9)	
	Other (Symptomatic Treatment)	17 (6)	13 (4.6)	
	Polypharmacy	7 (2.5)	10 (3.6)	
	Mixed / ECT	5 (1.8)	10 (3.6)	
	Observation/ Investigation+Symptomatic Treatment	6 (2.1)	12 (4.3)	
Outcome	Followup	123 (43.8)	64 (22.8)	0.69
	Referred	31 (11)	17 (6)	
	Admission	4 (1.4)	13 (4.6)	
	Referral and Follow up	11 (3.9)	18 (6.4)	

psychiatric referral from ER (n= 82, 29.5%) and IPD (n= 24, 8.5%). Psychotropic medications were mostly prescribed to IPD referrals (n= 92, 32.7%) than those referred to ER (n= 37, 13.1%) (Table 2).

DISCUSSION

In this study, we have studied the frequency and compared the presentation of psychiatric referrals sent from ER and inpatient departments of civil hospital Karachi.

Both male and female subjects were equally distributed in our study sample, this finding might occur by chance because they were being referred by doctors and not directly seeking help for themselves. However, literature also contradicts this and found that help-seeking behavior for mental health issues is relatively more pronounced among females than males. Thompson et al[9] and Liddon et al[10] in their previous works have studied the determining factors behind such repulsive behavior of males for availing help from mental health services. The most common factors were the difference in coping style, reliance on layperson sources for help, and unavailability of compatible mental health resources for them as per their distinct needs with that of females. Hence by deference to help-seeking for mental health, they ultimately present with severe Psychiatric disorders and avail psychiatric admission through ER.[11,12] We found young age group was most affected by the psychiatric presentation. The available literature is also consistent with such findings. Mental health problems i.e, depression, self-harm, substance use, psychosis, and anxiety disorders are more prevalent in the young age group. It is the most crucial time of life when an individual can utilize one's maximum potential to lay the foundation of important facets of life; educational, occupational, and social that are nurtured accordingly in the later years. Hence if this time gets affected by the mental illness its repercussive effects may be felt persistently in the subsequent part of life especially if remained unattended, ignored, or mismanaged in the initial time.[13,14] Unfortunately in our community the situation is almost similar, Ranjan work[15] showed that even in ER of tertiary care hospitals proper referrals to Psychiatrists are not made and only overly pronounced psychiatric conditions like acute psychosis and dissociative disorders grab attention despite the presence of other psychiatric conditions such as depression, anxiety disorders, stress-related disorders. Suicide and DSH were also high in ER patients and most of them who were referred to psychiatrists were not properly informed about the purpose of psychiatric referrals hence they either didn't avail themselves or complied with the Psychiatrist's advice or concealed their true accounts possibly due to stigma.[16] Certain healthcare departments hardly care about psychiatric

issues in their patients such as in intensive care units. The ICU patients have significant Psychiatric morbidities but that doesn't get the attention of the doctors due to their only focus on medical disorders that ultimately compromise the quality of life of patients and prolong ICU stay.[17] The initial presentation of Physical syndromes with Psychiatric symptoms is not invariably uncommon in spite that labeling them as Psychiatric disorders and referring them for psychiatric admission is disputable. It causes undue burden to patients and unreasonably delays adequate care. The reason behind this is the lack of following the systematic approach of assessment including history, physical examination, and laboratory investigations, and drawing any conclusion based on its findings.[18] In our study, the presence of referred patients with unexplained somatic syndromes was high which could be possible because the reason that majority of patients from ER were being referred even before formal medical assessment. To endorse the fair practice of referral, screening must be ensured by psychiatric nurses or trained ER doctors at the emergency department.[19] The local system of interdepartmental referral is almost similar to neighboring lower and middle-income countries. The psychiatric referrals from other departments do not fulfill the population level requirement holistically. Ignorance and mislabeling of mental health issues have become a norm.[20] This study has mirrored a few findings of the previous work i.e., young patients have commonly referred for the reason of acutely altered or disturbed behavior and an unexplained somatic symptom, major referring department was internal medicine with common psychiatric diagnoses were depression, somatoform disorders, and delirium.[21] Since medicine is the most referring department for Psychiatric consultation there should be a collaborative approach to maximize continuity of care addressing medical and psychological issues.[22] Delirium is the most common psychiatric diagnosis in the referred cases either go undetected or get only the Psychiatrist's attention While its predetermining factors such as old age, polypharmacy, comorbidities, cognitive impairment, illness severity, and complexity need the attention of all attending doctors for collaborative approach as a prudent option.[23]

This study helps gather the comparative information of two main referring bodies ER and inpatient departments for psychiatric consultation. The studied population and duration of the study were reasonably significant about previously conducted studies in India.[3,4,22] It will be helpful in the development of local policies regarding liaison services as suggested by Chen et al[24] from his systemic review to ensure the availability of an expert team of doctors at both referring and consulting ends in the general health system, especially in tertiary care teaching hospitals. It will hold promising results in terms of improving patient outcomes and satisfaction and reducing economic burden.[25,26] Currently, the application of liaison work is heterogeneous and inconsistent even in developed high-income countries. But the deficiencies can be identified and a care plan as per provided resources can be built up with prospects of better funding, training, and culturally adaptive services.[27]

The stakeholders should acknowledge the public mental health care as the general health care and devise focused training and research programs to endorse this consultation and liaison system. This will bring a remarkable change in the health practice in multiple ways; patient satisfaction and cost-effective utilization of resources both for physical and psychological health. Training of general health professionals is instrumental to improve collaboration and sustenance of liaison of mental health services with general health. In that way, patients would avail timely and best possible care under one roof. Suicide and other life-threatening emergencies also need triaged protocol of assessment for effective management, better outcome, and rehabilitation of patients as an ongoing process without discontinuity in care. For future research perspectives, multi-center studies are recommended to formulate interventions to implement a more adaptive and collaborative management approach to liaise mental health services in our setting.

In this study, if certain information of referred cases such as socioeconomic status, substance use (tobacco, etc), and marital status were available it would further add robustness to the available data in figuring out the confounding effects of those variables on the study outcome.

CONCLUSION

It can be concluded from this descriptive study that the overall frequency of Psychiatric referrals is very low to the population demand and It was more from inpatient departments than that of ER. Most of the cases at both places didn't classify into a particular psychiatric diagnostic category and referred just because of apparent behavioral disturbance and unestablished medical diagnosis possibly due to ambiguity in clinical presentation. The development of a liaison and consultation system is essential to ensure systematic assessment of patients at initial presentation whether in ER or outpatient department, So that misdiagnosis and delay in the provision of quality care may be avoided that otherwise creating a burden both for hospital and patients.

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Author's Contribution

AH conceived the idea, helped in the acquisition of data and drafting of the manuscript. SQ, KD, IJ and TA helped in the data collection and helped in revising the manuscript for final approval. Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflict of Interest

Authors declared no conflict of interest

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None

Data Sharing Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.