Referral patterns for psychiatric consultation in a large general hospital

A. E. GANGAT, L. R. NAIDOO, M. A. SIMPSON

Summary

Referrals for psychiatric consultation from all inpatient and outpatient departments in a large general hospital were analysed. There were 597 referrals — the combined inpatient and outpatient referral rate was approximately 0.78% and the inpatient rate 1.8%. The most common reasons for referral were parasuicide, depression/symptoms of depression, abnormal behaviour and alcohol abuse. Depressive disorders, drug dependence and neuroses were the most common diagnoses made. Medication was prescribed in 38% of cases and psychotherapy was offered in 18%. In 21% of cases the patient was either managed in his original ward or transferred back to the ward with advice regarding management. In 79% of cases management was within the Department of Psychiatry; many of these patients required concurrent treatment from the referring doctor for a physical disorder. The value of improving the quality and availability of consultation-liaison psychiatry services is discussed.

The discipline of consultation-liaison psychiatry responds to problems common to the psychiatric and non-psychiatric medical disciplines. It has the potential to shorten hospitalisation for the physically ill, improve their quality of life, and reduce morbidity and mortality. Patients seen by the consultation-liaison psychiatrist fall into three categories: (i) the physically ill with psycho-physiatric symptoms which either precipitate, exacerbate or maintain the physical condition; (ii) those with a psychiatric disorder who present with physical complaints but no evidence of disease; and (iii) those with a physical disorder in whom a psychiatric condition arises as a reaction to the physical illness. It follows that patient care in consultation-liaison psychiatry necessitates close joint involvement of both psychiatric and non-psychiatric practitioners.

Despite the obvious potential of this service, optimal use is not being made of the consultation-liaison psychiatrist. This is demonstrated by the fact that referral rates are far lower than the prevalence of psychiatric morbidity in the physically ill. Anstee1 and others2-7 quote referral rates of 0.5 - 10%. However, reports on psychiatric morbidity in the physically ill indicate that rates vary from 20% to 60%.4-7

There may be various reasons for this lack of recognition of and response to significant psychopathology in general hospitals.

These include a low index of suspicion for psychopathology coexisting with medical problems; lack of skills in managing and treating such conditions if identified; pessimism about the value of intervention in such cases; or, on the other hand, belief that they will respond to minimal or no intervention; and concern that patients will react unfavourably to referral.

So far, no report has been published on psychiatric consultations in South Africa.* We report on our experience in a large general hospital.

Subjects and methods

The study was conducted in the Department of Psychiatry, Addington Hospital, Durban, where 597 consecutive requests for consultation were received from various inpatient and outpatient departments during the 6-month period January - June 1985. Information was gathered from the consultation request form, the patient's case notes, discussions with the doctor or nurse most involved with the case and, when possible, the consultant physician. The information gathered focused on the variables of age, sex, source of referral, main reason for referral, diagnosis, management and outcome.

The first author (A.E.G.) had contact with all the patients reported on here.

Results

Referral rate

During the period January - June 1985, 232767 consultations were recorded in all outpatient departments at Addington Hospital. This figure includes repeat visits, and we estimate that one-third of this figure represents the actual number of new patients seen in this period, i.e. 77589 patients. Of these 597 patients were later referred to the Department of Psychiatry, which would represent a referral rate of about 0.78%.

During the same period 14448 patients were admitted. Of these, 259 (1.8%) were referred to the Department of Psychiatry. This referral rate is in keeping with an Indian study reporting a rate of 1.4% and a figure of 1.4% from a study in the UK. On the other hand it should be noted that Hackett9 reported a referral rate of 10% in his American sample.

Source of referral

Outpatient referrals constituted 57% and inpatient referrals 43% of the total. Of the 259 inpatient referrals, 70% were from medical and allied departments, 18% from surgical and allied departments, and 4% from the department of obstetrics and gynaecology. Anstee,1 in a study of 254 inpatient referrals in the UK, reported a distribution of 77%, 16% and 7% respectively, while Malhotra4 reported a distribution of 58%, 31% and 7% respectively in an Indian study of 336 inpatient referrals. Lipowski and Wolston,11 in an American study of 1000 patients, reported that 59% were referred from departments of medicine, 19% from departments of surgery and 14% from departments of neurology. The pattern of sources of referral in the present study is broadly in keeping with these world trends.

Main reasons for referral

Four main reasons for referral applied to 55% of referrals, viz. parasuicide (24%), depression (13%), abnormal behaviour (11%) and problems of alcohol abuse (7%). All the reasons for referral are listed in Table I. The main reasons for referral reported in other studies are similar, except that Malhotra in India did not encounter the suicide attempts or neurotic disorders which were prominent in other studies.

<table>
<thead>
<tr>
<th>TABLE I. MAIN REASONS FOR REFERRAL*</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parasuicide</td>
<td>141</td>
</tr>
<tr>
<td>Depression/symptoms of depression</td>
<td>75</td>
</tr>
<tr>
<td>Abnormal behaviour</td>
<td>68</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>43</td>
</tr>
<tr>
<td>Other†</td>
<td>42</td>
</tr>
<tr>
<td>Anxiety/symptoms of anxiety</td>
<td>37</td>
</tr>
<tr>
<td>Psychological/psychiatric assessment</td>
<td>36</td>
</tr>
<tr>
<td>Insomnia/sleeplessness</td>
<td>27</td>
</tr>
<tr>
<td>Aggressive behaviour/feelings</td>
<td>25</td>
</tr>
<tr>
<td>Headache</td>
<td>14</td>
</tr>
<tr>
<td>Substance abuse (other than alcohol)</td>
<td>13</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>13</td>
</tr>
<tr>
<td>Behaviour problem (in child)</td>
<td>12</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>12</td>
</tr>
<tr>
<td>Behaviour problem (in child)</td>
<td>12</td>
</tr>
<tr>
<td>Encopresis/enuresis</td>
<td>7</td>
</tr>
<tr>
<td>Sexual problems</td>
<td>5</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>4</td>
</tr>
<tr>
<td>Night terrors/nightmares/phobias</td>
<td>14</td>
</tr>
<tr>
<td>Child abuse</td>
<td>3</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>3</td>
</tr>
<tr>
<td>Poor school performance</td>
<td>3</td>
</tr>
<tr>
<td>Impaired memory</td>
<td>2</td>
</tr>
</tbody>
</table>

* There was more than one main reason for referral in some cases.
† Denotes all other categories including requests for disability grants, follow-up, requests for repeat medication, and multiple physical complaints.

Diagnoses

The most common diagnoses made — depressive disorder (33.3%), neuroses (14.7%) and drug dependence and alcoholism (12.1%) — are similar to diagnostic trends reported in India, the UK, the USA, Italy and Canada (Table II).

It is interesting to note that ‘No mental disorder’ is the fifth-commonest diagnostic category. A detailed review of these 39 cases indicates that no proper history was taken before referral, nor was a proper physical examination conducted (in a number of cases no physical examination was done).

Management

In most cases more than one treatment modality was used. In 224 cases (38%) medication was prescribed. In 105 cases (18%) individual psychotherapy/counselling/family therapy was offered. In 12% of cases intervention was restricted to assessment alone, this having been requested before renal transplantation or breast augmentation, or to advise on mental retardation and learning disabilities. In 6% of cases no psychiatric intervention was warranted.

Of the patients 364 (61%) were managed by a psychiatrist alone and 196 (33%) by a psychologist alone; the rest were seen by both. Malhotra reported a similar distribution of treatment modalities (medication/psychotherapy) in that 40% of her sample received medication while 17% received psychotherapy. Lipowski and Wolston report that psychotherapy was used in 38% of their psychiatric referrals and medication only in 36%.

Outcome

Of the patients 352 (59%) were referred to the psychiatry outpatient department for continuing care, 7.5% were admitted to the psychiatric ward, 6% were referred to a social worker, and 3% were referred to a psychiatric hospital. In 21% of cases the patient was either managed in his original ward or returned to the ward after assessment at the psychiatry outpatient department with advice regarding management.

Conclusions and discussion

A substantial number of patients with significant psychopathological conditions are identified and referred for psychiatric consultation, but the referral rate is relatively low in relation to the known prevalence of such conditions. Greater use should be made of psychiatric consultation services. Torem et al. have shown that a more ‘active’ than ‘reactive’ liaison approach increased the rate of referrals from 2% to 20%. In keeping with such an attitude, Addington Hospital has a developing liaison psychiatry service in which a specific psychiatrist or psychologist works continuously with patients and staff of certain medical units.

To meet the potential needs and to achieve the optimal benefits of a consultation-liaison psychiatry service, more and better-trained staff are necessary. Studies such as that of Koran et al. 14 have shown that patients generally appreciate referrals — they found that 72% were ‘pleased’ and some two-thirds felt that the consultation had been beneficial. Patients who were initially ambivalent or opposed to referral usually showed positive attitudes 24 hours later.

It should be recognised that clear medical benefit from such consultations has been demonstrated. Cassem and Hackett 15 found a threefold reduction in mortality in coronary-care patients who had been referred for psychiatric consultation. Billings 16 showed that adequate liaison reduced the length of inpatient stay. Levitan and Kornfeld 17 compared a group of elderly patients who had the help of a liaison psychiatrist postoperatively with a similar group without that benefit. The treated group stayed an average of 12 days less in hospital, and twice as many were able to return home. They
calculated the yearly saving for such patients to be $152,000. Goldberg et al.\textsuperscript{18} found that psychiatric attention was associated with a reduction in the use of laboratory and radiological services. Some studies have shown on follow-up that patients who are referred to a psychiatrist after a suicide attempt are less likely to repeat the attempt.\textsuperscript{19} Greer and Bagley\textsuperscript{20} found in an 18-month follow-up that patients who had received no psychiatric attention before discharge attempted suicide again more often (39\%) than those who had received brief psychiatric contact (26\%) or more prolonged psychiatric attention (20\%). In these and other ways, the greater availability of skilled psychiatric consultation-liaison services could improve the quality and cost-effectiveness of medical care.

REFERENCES


Victims of snakebite

A 5-year study at Shongwe Hospital, Kangwane, 1978 - 1982

S. L. McNALLY, C. J. REITZ

Summary

The epidemiology of snakebite in 251 patients admitted to Shongwe Hospital is described for the period 1978-1982. The incidence of bites, their seasonal variation, environmental and population factors, age and sex variations, the bite-site, bite-admission time and bite incidents are analysed. First-aid is frequently administered inappropriately even when given by a health professional. A pregnant patient who went into labour following a mild to moderate cytotoxic snakebite was delivered of a healthy premature infant. The dangers of snakebite during pregnancy are discussed.

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Shongwe Hospital is situated in Kangwane in the Transvaal, about 40 km from the southern border of the Kruger National Park and serves the Nkomasi area between the borders of Swaziland and Mozambique, which corresponds to Acock's\textsuperscript{2} vegetation type 10, with a small area of type 9. The climate is hot during the summer, winters are temperate and frost never occurs. The hospital and about 15 rural clinics serve a population of over 150,000, consisting mostly of rural black people, although urbanisation is in progress in certain areas. Agricultural activities include farming of sugar cane, tropical fruit and cattle.

There are about 160 species of snakes in southern Africa,\textsuperscript{2} mostly non-venomous. There are 8 venomous species in Kangwane that can cause death — black mamba (Dendroaspis polylepis), Egyptian cobra (Naja Raja annulifera), forest cobra...