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A Study of the Pattern of Psychiatry Referrals in Consultation Liaison at A Tertiary Care Hospital

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ABSTRACT

INTRODUCTION Psychiatry has a long tradition of attempting to reintegrate itself with medicine, a trend that was bolstered by the establishment of inpatient units and C-L (Consultation Liaison) services throughout the 20th century. Consultation-Liaison (C-L) Psychiatry is a clinical psychiatry subspecialty encompassing diagnostic, therapeutic, teaching, and research activities of psychiatrists and allied non-mental health professionals within non-psychiatric divisions of a general hospital.

AIMS AND OBJECTIVES: To study the patterns of psychiatry referrals related to other medical and surgical conditions at a Government General Hospital.

METHODOLOGY: A descriptive cross sectional study was conducted in PsychiatryDepartment,GGH,Vizianagaram.Convenient sampling was taken. Sample size was calculated by using the Formula n= Z*Z*P (1-P)/e*e .sample was collected until the sample size(395) is reached which lasted for 4 months.

RESULTS: 95.20% of the referrals were from within the hospital i.e., GGH whereas 4.80 % were from outside hospital. Majority of referrals were from the Department of General Medicine (n=248) amounting to 62.78%. Most common reason for referral was noted to be alcohol consumption (n=124) amounting to (31.39%) of the referrals, followed by suicide attempt (23.79%). Attempts were made to diagnose the individual before referral only in 15.18 % of all the referrals. Most common diagnosis made by the referring clinician was Substance Use Disorder. Of the 60 attempts made, 42(70%) were found to be in agreement with the Psychiatrist, whereas 30 % were not. 80.25% (n=317)were asked to follow up in OP, whereas 12 (3.03%) were opined to be in no need of further follow ups. 60 (15.18%) were advised for inpatient management in the GGH. 6 (1.51%) were referred to other departments in view of diagnostic evaluation or management.. Most common reason for suicidal attempt (n=94) was found to be strained interpersonal relationships, and second being acute stressors. Agrochemicals were commonly used in suicide attempt (n=68).

CONCLUSION: The comprehensive review of referral patterns and clinical characteristics in psychiatric consultations offers valuable insights into the diverse factors influencing the referral process and the nature of cases encountered in such consultations. The findings underscore the importance of addressing the specific needs of referred patients and implementing comprehensive care strategies to effectively manage psychiatric disorders in varied clinical settings. Further research and collaborative efforts are warranted to enhance the quality of psychiatric consultations and optimize patient outcomes.

***Keywords**: Psychiatry Referrals, reintegrate, medicine, surgical.*

INTRODUCTION

"Consultation" refers largely to the services performed for the physically ill patients and families, often at the bedside in the general hospital, upon the referral of the attending physician or other health professional."Liaison" refers to the services provided for the physician and staff, tying together the treatment of the patient and family using educational conferences, psychosocial teaching rounds and holistic treatment plans.[1]

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/surgeon.[2]

According to the European Association of CL Psychiatry and the Academy of Psychosomatic Medicine's consensus guidelines, the majority of patients encountered in CL psychiatry practice fall into one of the six groups listed below:[3]

1. Individuals with comorbid physical (medical) and psychiatric disorders where the management of each disorder complicates the management of the other.
2. Patients presenting with medically unexplained symptoms presenting in the clinical services.
3. Mental and behavioral disorders attributed to general medical conditions or their management.
4. Patients with psychiatric disorders presenting to medical setting for diagnostic or therapeutic procedures.
5. Individuals presenting with suicide or self-harming behavior in the medical setting.
6. Patients with health behavior, personality traits, cognitive function, or social condition that may influence the management of medical condition.

C-L psychiatry is now considered a subspecialty within the field of psychiatry. Its development has closely followed the transition of psychiatry from mental hospitals to general hospital settings. The increasing number of psychiatric units in general hospitals worldwide has led to a rise in consultation-liaison work conducted by psychiatrists in non-psychiatric departments of general hospitals. This has fostered closer connections between physical and psychological medicine, allowing psychiatrists to be directly involved in the care of physically ill patients.[1]

Benefits of C-L Psychiatry improves the course and outcomes of medically ill patients with psychiatric comorbidities and lowers healthcare costs. It enhances the quality of life and subjective experiences for patients and caregivers.

AIMS AND OBJECTIVES

Aim: To study the patterns of Psychiatry referrals related to other medical and surgical conditions at Government General Hospital.

Objectives:

1. To study the reasons for referrals and identify the specific departments from which these referrals originate.
2. To study the agreement between the diagnoses made by referring clinicians and those made by consulting psychiatrists.
3. To study the socio-demographic and clinical profiles of individuals referred for suicide attempt.

MATERIALS AND METHODS

STUDY DESIGN: Descriptive cross sectional study

STUDY SETTING: Department of Psychiatry , Government General Hospital, Vizianagaram

STUDY POPULATION: Cases referred to Department of Psychiatry

SAMPLING METHOD: Convenient sampling

SAMPLE SIZE: Sample size calculation for a cross-sectional study

- Formula n = Z*Z*P(1-P)/e*e , n= 1.96*1.96*0.5(1-0.5)/0.4*0.4 = 384
- n= The required sample size
- Z= The Z – score corresponding to desired confidence level. For 95% confidence level , Z=1.96
- P = estimated prevalence of the condition in the population. Use a value from previous studies or, if unknown, use 0.5 to maximize the sample size
- e= the desired margin of error (precision). This is value like 0.04 for 4% precision

STUDY PERIOD: Till the sample size is reached

INCLUSION CRITERIA:

1. All registered in patient and out patient referrals, to the Department of Psychiatry,Government General Hospital, Vizianagaram, who gave valid informed consent were taken into the study.

Family members who gave the consent for childen below 18years, they were taken into the study.

EXCLUSION CRITERIA:

1. Patients who were not willing to give consent.

METHODOLOGY

The study was conducted after obtaining approval from Institutional Scientific Committee and Institutional Ethics Committee, Government Medical College, Vizianagaram. All registered in patient and out patient referrals to the

Department of Psychiatry,Government General Hospital,Vizianagaram were included in the study till the sample size is reached. Sample size (n=395) was reached within a period of 4 months .This study examined the demographic details of the referred patients ,the reasons for referral, any diagnosis given by referring clinician ,the diagnostic agreement with the attending Psychiatrist's diagnosis and the modes of disposal.

STUDY TOOLS:

1. Semi structured Proforma : A semi-structured Proforma was employed to collect data, encompassing various study parameters such as patient's demographic details, sources of referral, reasons for referral, psychiatric diagnoses attempted by the referring clinician, diagnoses made (according to ICD-10) and interventions performed by the consulting psychiatrist.
2. Informed consent form: A self-designed informed consent form, detailing the nature of the study in vernacular language, was utilized to obtain informed consent from the study participants.

STATISTICAL ANALYSIS: The data was entered into Microsoft Excel and analyzed using the Statistical Package for Social Sciences version 20

RESULTS

TREND OF REFERRALS: A total of 395 referrals were collected over a period of 4 months, with an average of 3.29 referrals per day.

SOCIODEMOGRAPHIC DETAILS:

AGE DISTRIBUTION: The sample was distributed over an age range of 2 years to 89 years with the mean age of the sample being 38.94 years with standard deviation + or - 16.53 .Majority of the referrals were from the age group 31 to 40years (n=100) 25.31%

GENDER DISTRIBUTION: Of the 395 majority were males (n=265) constituting 67.08% of the sample.

RELIGION: Majority were Hindus (n=371) amounting to 93.92% of the sample followed by Christians (n=19) and Muslims (5)

EDUCATION STATUS: Majority were literates (n=202) amounting to 51.13% of the sample.

EMPLOYMENT STATUS: Majority were unemployed (n=201) amounting to 50.88% of the sample.

MARITAL STATUS: Majority were married (n=280) amounting to 70.88% of the sample.

PATTERN OF REFERRALS:

SOURCES OF REFERRALS: 95.20% of the referrals were from within the hospital i.e., GGH whereas 4.80 % were from other associated hospital (GOSHA) and from Government Area Hospitals and PHCs around Vizianagaram.

DISTRIBUTION OF REFERRALS ACROSS DEPARTMENTS: Majority of referrals were from the Department of General Medicine (n=248) amounting to 62.78%. These were followed by those from the Departments of Emergency Medicine (7.84%), Pulmonology (7.34%) and General Surgery (4.30%). Least number of referrals were from the Departments of ART (n=3), Urology (n=3) and Neurosurgery (n=2)

REASONS FOR REFERRAL: Most common reason for referral was noted to be alcohol consumption (n=124) amounting to (31.39%) of the referrals, followed by suicide attempt (n=94) 23.79%.

HISTORY OF MENTAL ILLNESS: Though 7 were referred in view of history of Mental Illness, after the interview held by the consulting Psychiatrist, 11 individuals were found to have a history of Mental Illness for which any kind of treatment was sought. But documents of previous treatment were not available with few of the individuals and no diagnosis could be made out in these because of either poor recall or no availability of reliable informants.

ATTEMPTS AT DIAGNOSIS BY THE REFERRING CLINICIANS: Attempts were made to diagnose the individual before referral only in 15.18 % of all the referrals.

PROVISIONAL DIAGNOSES MADE BY THE REFERRING CLINICIANS: Most common diagnosis made by the referring clinician was Substance Use Disorder

DIAGNOSES MADE BY THE CONSULTING PSYCHIATRISTS: After the initial interview, provisional diagnosis was documented by the consulting Psychiatrist. Of the 395, 78 had no diagnosable psychiatric disorder as per ICD 10. 34 patients required detailed evaluation and hence were asked for follow up and given no diagnosis. Of those diagnosed, substance use disorders were the most common (n=149) followed by Neurotic disorders (n=43)

DIAGNOSTIC AGREEMENT: The diagnostic attempts made by the referring clinician were compared with the diagnoses made by the consulting Psychiatrist at the end of the interview. Of the 60 attempts made, 42(70%) were found to be in agreement whereas 30 % were not.

MODES OF DISPOSAL: Of the 395, 317 (80.25%) were asked to follow up in OP, whereas 12 (3.03%) were opined to be in no need of further follow ups. 60 (15.18%) were advised for inpatient management in the GGH. 6 (1.51%) were referred to other departments in view of diagnostic evaluation or management.

STUDY OF THE SUICIDAL ATTEMPTS:

Details of the sample referred in view of suicidal attempts (n=94) were explored further and the following observations were made.

REASONS FOR ATTEMPTS: Reasons as given by the individual were documented verbatim and categorized accordingly. 6 individuals were not willing to share the reason for the attempt accounting to 6.68%. Most common reason was found to be strained interpersonal relationships, including those with the parents, romantic partner/spouse and at the workplace. Second most common reason was acute stressors and third most common reason being consumption of toxic substances under intoxication of alcohol. Acute stressors include death of a family member, exam stress and newly diagnosed medical illness. Individuals consumed toxic substances accidentally, mistaking it for something edible but as the referral note mentioned "suicidal attempt" it was also considered here.

MODE OF ATTEMPT: Agrochemicals (insecticides, pesticides, herbicides, rodenticides, fungicides) were commonly used to attempt (n=68), 72.34 % of the 94 individuals. Disinfectants (phenol, lysol) followed next (n=12).

HISTORY OF PREVIOUS ATTEMPTS: Past history of suicide attempts was noted in 11 individuals.

SUBSTANCE USE: Of the 94 individuals, 19 (20.21%) had history of substance use, all of them being male, out of which 10 (52.64%) consumed alcohol, whereas 9 (47.36%) consumed alcohol and nicotine in any of its forms.

TABLE 1: AGE Distribution

Measures	Values
Mean	38.94 years
Standard deviation	+ or - 16.53 years
Median	38 years
Mode	40 years
Range	2 to 89 years

TABLE 2: SOCIODEMOGRAPHIC DATA

Age Range	Frequency	Percent
1 -10 years	8	2.02
11 – 20 years	46	11.64
21 – 30 years	78	19.74
31 – 40 years	100	25.31
41 – 50 years	75	18.98
51 – 60 years	41	10.37
61 -70 years	29	7.34
71 – 80 years	16	4.05
81 – 90 years	2	0.05
Gender	Frequency	Percent
Male	265	67.08
Female	130	32.91
Domicile	Frequency	Percent
Urban	74	18.73
Rural	321	81.27
Marital status	Frequency	Percent
Married	280	70.88
Unmarried	115	29.23
Education status	Frequency	Percent
Educated	202	51.13
Uneducated	193	48.86
Religion	Frequency	Percent
Hindus	371	93.92
Christians	19	4.81
Muslims	5	1.26

Employment status	**Frequency**	**Percent**
Employed	**194**	**49.11**
Unemployed	**201**	**50.88**

TABLE 3: Distribution of Referrals across departments

DEPARTMENT	Frequency	Percent
General medicine	248	62.78
Emergency medicine	31	7.84
Gynecology	4	1.01
Paediatrics	8	2.02
Neurology	16	4.05
Pulmonology	29	7.34
General surgery	17	4.30
Orthopaedics	13	3.29
Dermatology	7	1.77
Neurosurgery	2	0.50
ENT	7	1.77
Urology	3	0.75
ART centre	3	0.75
Outside hospital	7	1.77
Total	395	100

TABLE 4: Reasons for referral

Reason for referral	Frequency	Percentage
Abnormal behavior	36	9.11
Substance use	124	31.39
Altered sensorium	18	4.55
Seizures for evaluation	12	3.03
Somatic complaints	73	18.48
Fitness for surgery	3	0.75
H/O mental illness	11	2.78
Developmental delay	2	0.50
Suicidal attempt	94	23.79
Not mentioned	22	5.56
Total	395	100

TABLE 5: Diagnoses made by consulting Psychiatrists

ICD 10 Diagnosis	Frequency	Percent
F00 –F09	34	8.60
F10 –F19	149	37.72
F20 –F29	17	4.30
F30 –F39	19	4.81
F40 –F48	43	10.88
F50 - F59	10	2.53
F60 –F69	5	1.26
F70 –F79	2	0.50
F80 –F89	4	1.01
NOT YET DIAGNOSED	34	8.60
Z03.89	78	19.74
TOTAL	395	100

TABLE 6: Diagnostic agreement

Diagnostic agreement	Frequency	Percent

Correct	**42**	**70**
Incorrect	**18**	**30**
Total	**60**	**100**

TABLE 7: Modes of disposal

Mode of disposal	Frequency	Percent
Adviced review in OP	**317**	**80.25**
Adviced IP admission	**60**	**15.18**
Single visit and OP disposal	**12**	**3.03**
Referred to other consultants	**6**	**1.51**
Total	**395**	**100**

TABLE 8: Reason for suicide attempt

Reason for suicide attempt	Frequency	Percent
Accidental consumption	**5**	**5.31**
Acute stressors	**13**	**13.82**
Financial stressors	**10**	**10.63**
Reasons not revealed	**6**	**6.38**
Somatic complaints	**3**	**3.19**
Strained interpersonal relationships	**46**	**48.93**
Under intoxication	**11**	**11.70**
Total	**94**	**100**

TABLE 9: Distribution of reasons for attempt across genders

Reason for suicide attempt	Male	Female
Accidental consumption	**5**	**0**
Acute stressors	**2**	**11**
Financial stressors	**6**	**4**
Reasons not revealed	**2**	**4**
Somatic complaints	**0**	**3**
Strainedinterpersonal relationships	**20**	**26**
Under intoxication	**11**	**0**

TABLE 10: Mode of attempt

Mode of attempts	Male	Female
Agrochemicals	**36**	**32**
Disinfectants	**4**	**8**
Hanging	**3**	**0**
Self inflicted injury	**1**	**1**
Tablets	**0**	**4**
Unknown compounds	**0**	**2**
Others	**2**	**1**

TABLE 11: History of previous Suicidal attempts

History of previous attempts	Frequency	Percent
Present	**11**	**11.70**
Absent	**83**	**88.29**
Total	**94**	**100**

TABLE 12: History of substance use

History of substance use	Frequency	Percent
Yes	**19**	**20.21**

No	**75**	**79.78**
Total	**94**	**100**

DISCUSSION

Study Overview

During an 4 month study period from December 2025 to March 2026, Psychiatry Department of Government General Hospital ,Vizianagaram received a total of 395 referrals from various departments within and outside the hospital. The study aimed to collect and analyze demographic details of the referred patients, the reasons for referrals, attempts to diagnose by the referring clinicians, diagnostic agreements with the consulting Psychiatrists, and modes of disposal. Data was gathered using a semi-structured proforma.

Demographic Details

An average of 3.29 referrals per day. Whereas, in comparison, a study by Singh PM et al. reported an average of 3 referrals per day[4]. Of the 395 referrals, a majority were males (67.08%), consistent with findings by Bhogale et al.[5] who reported that more than two-thirds of referred patients in their study were males. Chatterjee and Kutty[6] conducted a study in military hospital setting where 88% of the referred patients were males.The patients' ages in our study ranged from 2 to 89 years, with a mean age of 38.94 years (SD = 16.53). Most individuals were in the 31 to 40 yrs age group (25.31%), followed by those in the age group of 21 to 30 (19.74%). Keertish et al.[10] in their study reported that the majority belonged to the 16-45 age group. But results seen in the studies of Aghanwa et al.[7] and Bhogale et al.,[5] reported 61.6% and 70% of patients in 20 to 30 years age group respectively. In our study, 11.44% of the referred patients were above the age of 60 years. This was in accordance with the findings of other Indian studies. In the study by Keerthish et al[10] the proportion of the referred patients in the age group of more than 65 years was 8.8%. Jhingan [8] showed that 8% of the study population was above 60 years and Bhogale et al [5] found that 3.3% of the referred patients were older than 65 years. In contrast, western data suggest that the percentage of referrals in this age group is quite high.[20] This could be due to various local factors like a lesser life expectancy, a lack of awareness about geriatric conditions like dementia, preference of alternative systems of medicine like Ayurveda, Homeopathy and Unani and family neglect. Also, Indian families have a tendency by to accept geriatric problems as age related and normal. Additionally, 93.92% of the patients were Hindus, 51.13% were literate, 50.88% were unemployed, and 70.88% were married.

Referral Sources and Reasons

A majority of referrals i.e. 95.20% or 388 referrals were from within the hospital, with 248 referrals from the Department of General Medicine, followed by 31 from Emergency Medicine, and 29 from Pulmonology. These findings align with studies by Bhogale et al.[5] Sharp J et al.,[22] Singh PM et al.,[4] Michalon M et al.[9] Keertish et al.,[10] where most referrals originated from General Medicine. The most common cause for referral was substance intake and its related effects 31.39%, or 124 referrals. .All the substance use cases with withdrawl symptoms or medical complications will be initially admitted in General Medicine Department and later referred to Psychiatry Department for deaddiction. Due to stigma very few substance use cases directly approach Psychiatry OPD .They prefer General medicine dept to Psychiatry dept. This was contrast to the findings of Singh et al.[4] which showed that 14.5% of the referrals were caused by substance use and Keertish et al.[10] showed 11.3%. Some studies showed that a lower percentage (2-5%) of patients were referred for substance use, which the authors attributed to a lack of affordability .The second most common reason for referral was suicidal attempts (23.79%) or 94 referrals .It is probable that the majority of cases brought to the emergency department following suicidal attempts are admitted to the General Medicine Department and then referred to the Psychiatry Department in order to rule out any underlying mood disorders, address them, and prevent future attempts therefore bringing majority of referrals from the department of General Medicine. A study by Keertish et al. showed negligible amount of referrals due to self-harm (1.35%) whereas, Sharp J et al[22].found depression to be the most common reason in their study, while Chen CY et al.[11] identified suicidal risk evaluation as a primary reason (33.14%) in their study. In a study by Feldman et al.[21] the most common reason given for requesting a consultation was to evaluate a patient's potential to develop depression or attempted suicide. In our study18.48% (n=73) of the referrals were for somatic complaints. Medically unexplained somatic symptoms were the most common reason for referral noted in the study by Keertish et al..[10] This was lower than those in the findings in other studies, which have shown that medically unexplained somatic complaints accounted for 30%[12] and 54%[5] referrals.

Suicidal Attempts Analysis

Of the 94 individuals referred for suicidal attempts, strained interpersonal relations were a common stressor in 46 individuals (48.93%) which included relations with the parents, romantic partner/spouse and those at workplace. And 13 (13.82%) attempted due to acute stressors, the second most common reason and 11 patients attempted under intoxication. In a 5-year study at PGIMER, Chandigarh, 78% of individuals had a precipitating event, with interpersonal problems (54.9%) and alcohol consumption (17%) being notable factors.[13] Previous suicidal attempts were reported in 11.70% (n=11).The most common suicide method was agrochemicals n=68 (72.34%), followed by disinfectant consumption (12.76%). Das PP et al. reported insecticides (44.6%) and corrosives (17.5%) as common methods used for attempts in

their study. Venkoba Rao[14] in his article on attempted suicide among students, reported that the most common mode was insecticide ingestion.

Substance Use History

Of the 94 individuals, 19 (20.21%) had a history of substance use .all of them being male, out of which 10 (52.64%) consumed alcohol, whereas 9 (47.36%) consumed alcohol and nicotine in any of its forms. Michalon M et al.[9] found 42% of suicidal patients were dependent on alcohol. In our study, all the individuals who had history of substance use were males. This aligns with the local pattern of use where males are more likely to be dependent than females.

Previous Mental Illness

Among the 395 referred patients, 12 had a previous history of mental illness,. Details of mental illness were not accessible in few of cases and no diagnosis could be made out in these by the consulting Psychiatrist because of either poor recall or no availability of reliable informants. Sathyanarayanarao TS et al. found that 24.4% of referred individuals had one or more diagnosable psychiatric disorders, with depressive disorders (14.82%), anxiety disorders (4%), and substance use disorders (3.95%) being prevalent.[15]

Diagnostic Attempts and Agreements

Referring clinicians attempted diagnoses in 60 referrals 15.18%), with 84.82% left undiagnosed. Of the 60 diagnoses attempted, 42(70%) agreed with the consulting Psychiatrist's diagnosis, while 18 (30%) did not. The most common diagnosis by referring clinicians was substance use disorder, likely due to the detectability of the physical presentations of withdrawal of substance which are common knowledge among the general physicians and surgeons as they align with the common disorders they treat on a day to day basis because of the associated significant medical and surgical morbidities. In a 5-year study, non-psychiatrists' recognition accuracy of psychiatric illness was 41.5%, with substance use disorders having the highest agreement.[13] In a large multicentric study by Costanzo et al.,[16] an ICD-10 diagnosis was made by consultants in 83% of cases, in 5% diagnosis was deferred, and in 12% no psychiatric diagnosis was made.

Psychiatric diagnoses

In our study, 78 had no diagnosable Psychiatric disorder as per ICD 10. 34 required detailed evaluation and hence were asked for follow up and given no diagnosis. Of those diagnosed, substance use disorders were the most common (n=149) amounting to 37.72% followed by neurotic disorders (n=43) amounting to 10.88%. The lower percentage of patients with Psychoses in studies by Neki and Kapoor [17]and Chadda et al.[18] was attributed to the presence of a mental hospital in the vicinity of the GHPU facility, similar to which, the individuals with unmanageable Psychotic disorders might have been directed to Government Hospital for Mental Care, (GHMC) Visakhapatnam which is the only tertiary Psychiatric centre for the state of Andhra Pradesh instead of referral to the Government Hospital Psychiatry Unit, Vizianagaram.

Disposal Modes

Of the 395 referrals, 80.25 % were advised to follow up on an outpatient basis, 3.03% required only a single visit for a psychiatrist's opinion, 1.51% were forwarded to other departments, and 15.18% needed inpatient care and were advised admission to the Government general hospital,Viziznagaram. Wong et al[.19] reported that 50% of patients were advised outpatient follow-up, while 4% required referrals to other services in their study. In Costanzo et al.'s study, psychological intervention was carried out in 73% of the consultations and 2.1% of the patients were transferred to psychiatric units.[16]

LIMITATIONS

Referral rates may not be accurate, as not all cases requiring psychiatric attention may have been referred. This could be due to lack of time and awareness of psychiatric symptoms among clinicians and stigma among patients and family members regarding consulting a psychiatrist. Further exploration of details such as family dynamics, the pattern of substance use among individuals who have attempted self-harm, and family history of mental illness among individuals with diagnosable psychiatric disorders could have been beneficial. Individuals with possible sub-threshold symptoms may not have been referred or assigned an ICD 10 diagnosis, which might have led to an underestimation of the burden of psychiatric morbidities. The time delay from the time of admission to the psychiatric referral was not studied, which could have provided a more accurate evaluation of the awareness of clinicians regarding the detection of psychiatric disorders. As follow-up was not conducted, the effects of psychiatric intervention could not be studied.

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