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Letter to the editor

Referral patterns in a consultation liaison psychiatry service in India: A comparison with the Western world

Consultation liaison (CL) psychiatry services are not well developed in India [1]. The general hospital psychiatric units (GHPUs), which are predominant provider of mental health services in the country, also provide CL psychiatry services in addition to routine outpatient and inpatient psychiatric care [2]. Most of the CL psychiatry services work on a consultation model with little liaison work. Exclusive CL psychiatry units are available at a limited number of places, mostly in tertiary care settings [1]. Authors compared the referral patterns at a CL psychiatry service in a tertiary care general hospital in India with some of the services from different parts of the world to understand the similarities and differences across various countries.

The site of the study was a GHPU in North India, which has bed capacity of 2439 and caters to the needs of about 3.35 million outpatients and 210 thousand inpatients annually. The institution has been following a consultation model of psychiatric service in the general hospital setting. The CL psychiatry service is provided by the depart-

Table 1
Comparison with referral patterns from international studies.

Author; Site of Study	Duration	N	Age[1]	Source of referral[2]	Common diagnosis[2]
Current study New Delhi India	2 yrs. (March 2014-Februray 2016)	2355	43.21 (18.1)	Medicine & allied (41.6); Surgery & allied (21.2); Neurosciences (11.1); Trauma & emergency (10.0); Oncology (6.2); Dermatology (3.5); ObGyn (2.8); Others (3.6)	Delirium (16.0); Depression (11.1) Substance use disorder (7.3); Anxiety disorders (10.8); Bipolar disorder (4.3); Psychotic disorder 4.8); Adjustment disorder (3.6); Organic brain disorder (3.3); Deliberate self-harm (3.2); Others (3.4); No psychiatric problem (32.1)
Diefenbacher [3] Berlin, Germany	1 yr (1991-1992)	280	51.2 (20.1)	Medicine and allied (49.2) Cardiology, Gastroenterology & Oncology (13.5); Surgery (20.7); Dermatology (10.7)	Current psychiatric symptoms (51.8); MUPS (16.1); Suicide attempt (16.1); Substance use (3.6)
Diefenbacher & Strain [4] New York, USA	10 years (1988-1997)	4429	52.2 (18.8)	Medicine & allied (50.3); Surgical (19.2); Neurology (5.4); ObGyn (4.4) Transplant (2.9)	Organic brain disorder (40.1) Depression (28.1) Substance use disorder (8.5)
Huyse et al [5] 11 European Countries and 56 CL services	1 yr. (1991)	14717		Medicine (55); Surgical disciplines including Ophthalmology.& Otolaryngology.(19) Neurology (10) ObGyn (4.5)	DSH[3] (17); MUPS[4] (65); Current psychiatric symptomatology (40); Mood disorder (18.7); Organic mental disorder (17.7); Substance use disorder (13.3); Adjustment disorder (12.4) Dissociative & Somatoform disorder (7.5)
Lyne et al [6] Dublin, Ireland	6 months (July Dec 2007)	172	54.3 (20-86)		Substance use disorder (25.0); Depressive disorder (18.0); Delirium (14.5); Anxiety disorder (13.4); Psychotic disorder (5.8)
Onofa et al [7] Abeokuta, Nigeria	2 yr (2009-2010)	298	40.6 (15.8)	Different medical specialities	Depression (23.8); Schizophrenia (20.5); Anxiety disorders (10.1); Somatoform disorders (5.2); Organic brain disorder (10.7); Epilepsy (14.1)
De Georgia et al [8] Perugia, Italy	1 yr (2009-2010)	932	57.4 (19.4)	A&E (29.5) Medical (53.1) Surgical (8.8) Specialist (38.1)	Anxiety (18.9); Depression (18.2); Confusion (13.4), MUPS (11.2); Suicide attempt/risk (11.2); Agitation (10.9); Previous psychiatric illness (14.4)
Sanchez-Gonzalez et al [9] Barcelona, Spain	10 years (2005-2014)	9808	55.3 (17.4)	Medicine and allied (32.4), Neurology (12.2), Haemato-oncology (9.1), Surgery (8.1), Cardiology (8.0), Trauma (5.7)	Substance use disorder (23.7); Delirium (15.9); Dementia (6.2); Adjustment d (16.0; Depression (7.2);Anxiety d (5.9); Schizophrenia (4.0); Bipolar disorder (2.1)

[1] Figures in parenthesis SD.
[2] Figures in parenthesis are %, Total may not be 100, because of missing values.
[3] DSH- Deliberate self-harm.
[4] MUPS- Medically unexplained physical symptoms.

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ment of psychiatry and receives referral during working hours form different disciplines in the hospital. In the three-tier system, all cases are first evaluated by a trainee psychiatrist under the supervision of a qualified psychiatrist and are finally reviewed by a consultant psychiatrist. A retrospective chart review of all the referrals made to the CL psychiatry services of the hospital was undertaken for a period of two years (March 2014 to February 2016) from CL psychiatry case register. ICD 10 diagnostic system was used to make a diagnosis.

The service received 2355 referrals over the period of 2 years, at a rate of 4.4/day and 0.6/bed/year. About 60% of the subjects were male, with most (97.2%) being adults. About one fifth (19.2%) of the subjects were above 60. More than 40% of the referrals came from medicine and allied disciplines, and about 20% came from surgical disciplines. Neurosciences and trauma services contributed to about 10% each of referrals (Table 1). Delirium, depression and anxiety disorders were the three commonest diagnoses. Thirty two percent of the subjects did not receive any psychiatric diagnosis. Mean age of the subjects with delirium was 50.57 years. Seventy-six (3.2%) patients had been referred for an attempt of deliberate self-harm (DSH), with 2/3rd being males. Mean age of patients presenting with DSH was 29.3 (SD-3.41) years. The most common methods of self-harm were organophosphorus pesticide ingestion, cutting self and acid ingestion.

Reason for about one third of our patients not receiving a psychiatric diagnosis was because about one fifth (469) of our subjects were prospective donors and had been sent for psychiatric clearance from the organ transplantation services (nephrology, oncology and gastrointestinal surgery) of the hospital. Out of them, only 4 subjects received a psychiatric diagnosis. Patients with delirium were about 7 years older and those with DSH were about 14 years younger than the average sample, which is explainable by the general age profile of these two conditions. DSH being more common in males was another unusual finding, since it is more commonly reported in females. Organophosphorous pesticide ingestion was the commonest method of DSH as also reported in earlier work from India [3].

We compared our findings with some similar studies from different parts of the world [4–10] (Table 1). The sample size in our study was reasonably large, comparable to the studies shown in the table. Mean age of our subjects was lower compared to the Western studies [4–7,9,10], but somewhat similar to the Nigerian study [8]. The age difference can be explained by differences in demographic of the countries. In most of the studies, medicine and allied disciplines were the most common source of referrals to CL psychiatry, and delirium, depression and substance use disorders were the three common reasons for seeking consultation. Alcohol use was the most common substance of use. Our findings were also along the same line. Medically unexplained physical symptoms (MUPS) or the functional somatic symptoms were a common reason of referral in some of the studies [4,6,9]. We did not have MUPS as a diagnostic group, since these patients might have been represented in patients with depression, anxiety and adjustment disorders. Broadly, the diagnostic profile in our subjects was similar to the Western studies and Nigeria. To conclude, there are no major differences in the psychiatric problems seen in various medical and surgical specialities and in a general hospital and CL psychiatry referral patterns across different countries.

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