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Liaison Psychiatry in Current Clinical Practice

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Abstract:
Background: *Direct psychiatric consultation is not still prevalent in India, even in health care professionals due to stigma regarding mental illness. This delay in referral and failing to identify psychiatric symptoms in the right time is responsible for undue morbidity. Hence studies regarding cross referrals and liaison psychiatry is the need of the hour in providing comprehensive health care to the patients. It is really welcoming sign that mental health services had moved from mental hospital to a general hospital setting which made the availability of psychiatric services closer to the public and made an effort to reduce the prevailing stigma* ***Materials and Methods:*** *Referrals to Psychiatric Department were assessed for six months period with 505 patients. Out of these, 384 were inpatients referred from the general hospital and other hospitals, 59 were outpatients referred from various specialities, and 62 were from the emergency unit.* ***Results:****. Only one-fifth of cases diagnosed of which around 50% given diagnosed appropriately by clinicians. Single-visit and opinion was the most common mode of disposal* ***Conclusion:*** *Impulsive Suicidal attempt and Deliberate self harm are the most common reason for referral. Mood disorders are a common psychiatric illness observed in individuals attending medical emergencies.*

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I. Introduction

General hospitals have an essential role in the evolution of psychiatry. They have provided soil for the growth of inpatient psychiatric units, consultation-liaison psychiatry, psychosomatic medicine, med-psych units, outpatient psychiatric clinics, emergency services and a whole spectrum of resources for the communities in which they exist. General hospital psychiatry units have provided increased opportunities for interaction between psychiatrists and other medical specialists, making consultation-Liaison Psychiatry more meaningful [1].

It is welcoming issue that psychiatric services had moved from mental hospital to a general hospital psychiatric unit which made the availability of psychiatric services closer to the public and made an effort to reduce the stigma

II. Materials &Methods

The present study had been conducted in the Department of Psychiatry, Sri Venkateswara Medical College, Tirupati. The hospital is a Tertiary General Hospital with about 1200 beds covering all disciplines like Casualty, General Medicine, General Surgery, Paediatrics, Dermatology, Ophthalmology, ENT, Paediatric Surgery, NeuroSurgery, Gastroenterology. All departments run OPD. Hospital related to obstetrics and gynaecology is separate one (Government Maternity Hospital, GMH).

Inpatient and outpatient referrals, including emergencies to the Department of Psychiatry, were taken to study over for six months. All the referrals registered at Psychiatric OPD. Referrals coming from an outside source apart from the general hospital also included. Patients were informed about the purpose of the study, and voluntary written consent, taken before their inclusion. Confidentiality of the patient was maintained. Those who do not give consent and prisoners, excluded from this study. A proforma containing all the parameters of the study like demography, source of referral, reasons for the referral, psychiatric diagnosis given by the referring unit, diagnosis made at the psychiatric unit documented. All the particulars of the referred cases noted in consultation with the referring doctor. Inpatient and outpatient, including emergencies, were noted separately. The psychiatric diagnosis confirmed according to International Classification of Diseases (ICD-10), and necessary intervention was done.

III. Observations And Results

Total referrals to Psychiatric Department were 505 during six months period. Out of these, 384 were inpatients referred from the general hospital and other hospitals, 59 were outpatients referred from various specialities, and 62 were referred from the emergency unit.

Table 1: Sex, Age, Patient distribution and Marital status

	IP	OP	Total
Number of patients referred	384	121	505
Sex			
Males	210	71	281
Females	174	50	224
Age			
Up to 20 years	66	17	83
21-50 years	279	91	370
>50 years	39	13	52
Education			
Illiterates	104	37	141
Up to secondary education	184	48	232
Above secondary education	96	36	132
Marital status			
Married	275	93	368
Unmarried	109	28	137

In the present study, 55.7% were males, and 44.3% were females. 21 to 50 year age group were referred more than other age group both among males (33%) and females (45.9%). 73.2% population belonged to 21-50 years age group. Paediatric age group was the least referred group (3.3%). Even the age group >60 years was low (5.3%).

Regarding data of education levels, most of the patients finished primary education (61.1%), among those who are studying /stopped in secondary school level constituted the highest number (35%). Illiterates are of 27.9%, second highest group in educational status.

Table 2: Diagnostic attempts by Referring Clinician

S.No.	Diagnosis	Finding	No. of cases	Percentage
1	Attempted	Appropriate diagnosis	47	10.6%
		Wrong diagnosis	38	8.6%
2	Not attempted		358	80.8%
	Total		**443**	**100.0%**

Only 19.2% (85 cases) of 443 cases were attempted to put a diagnosis, of which about 55.29% of patients were on appropriate diagnosis. Overall, only 10.6% of the total cases were on appropriate diagnosis.

Table 3: Psychiatric diagnosis made by referring clinician

S.No.	Diagnosis by clinician	No. of Cases	Percentage
1	Major Depressive Episode	23	27.06%
2	Psychotic Disorders	8	9.41%
3	Anxiety Disorders	14	16.47%
4	Conversion Disorder	3	3.53%
5	Substance related disorders	22	25.88%
6	Others	15	17.65%
	TOTAL	**85**	**100.00%**

The most common diagnosis made was Major Depressive Episode (27%), followed by Substance-Related disorders (25.88%). Among 22 patients of Substance-Related disorders, 13 patients, were referred to the Psychiatry department with a diagnosis of Alcohol Dependence with Withdrawal features and others for de-addiction. Three patients were confirmed to be suffering from Conversion disorder.

Table 4: Treatment given by the Referring Doctor

S.No.	Drugs	In patients	Out patients	Total	Percentage
1	Antipsychotics	2	1	3	6.00%
2	Anti-depressants	6	8	14	28.00%
3	Benzodiazepines	16	11	27	54.00%
4	Others	4	2	6	12.00%
	Total	**28**	**22**	**50**	**100.00%**

The Total number of cases for which psychiatric treatment attempted was 50. Half of the cases were on treatment with benzodiazepines, and about one-fourth of patients were prescribed antidepressants. Only 11% of total cases were given some medication before psychiatrist opinion.

Table 5: Diagnoses made by Psychiatrist according to ICD-10

S.No	ICD Code	In patients	Out Patients	Total	Percentage
1	F00-09	23	5	28	6.3%
2	F10-19	49	7	56	12.6%
3	F20-29	17	4	21	4.7%
4	F30-39	61	19	80	18.1%
5	F40-49	13	10	23	5.2%
6	F50-59	8	2	10	2.3%
7	F60-69	0	0	0	0.0%
8	F70-79	6	6	12	2.7%
9	F80-89	0	0	0	0.0%
10	F90-98	0	0	0	0.0%
11	X CODE	178	2	180	40.6%
12	Z,Y CODE	3	0	3	0.7%
13	No Psychiatry diagnosis	24	2	26	5.9%
14	G code	2	2	4	0.9%
	TOTAL	**384**	**59**	**443**	**100.0%**

Though many cases had multiple diagnoses, the official diagnosis of the patient given priority, The most common diagnosis found in the referral cases fall under X code of ICD-10, and 40.6% were impulsive suicidal attempts. Among the psychiatric illnesses, mood disorders were most common in both inpatients and outpatients population. No Psychiatric diagnosis was there in a considerable number of patients (5.9%).

Table 6: Mode of Patient Disposal

S. No	Type of Disposal IP	Inpatients	Out patients	Total	Percentage
1	Single visit and opinion	207	3	210	47.4%
2	Outpatient continuation	98	36	134	30.2%
3	In patient treatment in the same set up	52	5	57	12.9%
4	Transfer to psychiatry in patient care	11	6	17	3.8%
5	Referred to other departments	16	9	25	5.6%
	Total	**384**	**59**	**443**	**100.0%**

Single-visit and opinion was the most common mode of disposal done both among inpatients and outpatients (47.2%). Next mode of disposal was an outpatient continuation, advised to the patients who had a psychiatric diagnosis to regular followups. Only 13 cases (2.9%) required inpatient treatment in the psychiatry ward. Inpatient care in the same department from where the referral came was also significant, 3.8%, which requires constant association between a psychiatrist and other clinicians.

EMERGENCIES

Total cases referred from casualty were 62, among these 33 were males, and 29 were females.

The most common reason for the referral from emergencies was abnormal behaviour (51.6%), followed by a history of psychiatric illness (17.7%). Suicidal ideation or attempts were 6%. Abnormal behaviour in the form of aggression was seen almost in equal number in males and females. Abnormal bodily movements identified in five patients (4 males, one female). Suicidal attempt as referral observed in two males and two females.

Diagnosis by a Psychiatrist in Emergency

The most common diagnosis made by attending psychiatrist in the emergency department was Mood Disorder (30.6%) followed by Substance use Disorders (16%). Among mood disorders, manic excitement was the most frequent(63%, 12 cases out of 19). Other mood disorders seen are Moderate Depressive Episode with Conversion Symptoms (3 cases), Severe Depression with psychotic features (3 cases) and one case of Recurrent Depressive Disorder currently Severe Depression with Psychotic features.

Psychiatric illness commonly observed in Females was more of Mood Disorders followed by Neurotic, Stress-related and Somatoform disorders, and Males were suffering from Substance-related Disorders followed by mood disorders.

Table 7: Diagnosis Attempted by Referring Doctor in Emergency

S.No.	Diagnosis		No. of cases	Percentage
1	No diagnosis attempted		41	66.1%
2	Diagnosis attempted	Appropriate diagnosis	14	22.6%
		Wrong diagnosis	7	11.3%
	Total		**62**	**100.0%**

Attempts made by the referring doctor to diagnose the cases constituted about one-third of total emergencies, out of which 14 cases (66.6%), appropriate diagnosis amounting to 22.6% of total referred.

Table 8: Treatment Given by Referring Doctor in Emergency

S.No.	Drugs used	No. of Cases	Percentage
1	Anti-psychotics	2	25%
2	Anti-depressants	0	0%
3	Tranquilisers	6	75%
4	Mood stabilizer	0	0%
	Total	8	100%

Out of 62 cases referred yo psychiatrist, only 8 (12.9%) patients have undergone treatment. Tranquilisers used in Six cases (75%). Five patients were given Injection Diazepam intravenously, and one patient has given Tablet Clonazepam 0.5 mg. Only two patients given Haloperidol Injection 5 mg. Predominantly Mood disorders with Manic excitement (12 cases) were common in this study and Suicidal Ideation/ Deliberate Self-harm (Four cases).

Table 9: Mode of Disposal of Patients in Emergency

S. No.	Mode of disposal	No. of cases	Percentage
1	Single visit and opinion	2	3.0%
2	Outpatient continuation	8	12.9%
3	In patient treatment in the same set up	10	16.0%
4	Transfer to psychiatry in patient care	33	53.0%
5	Referred to other departments	9	14.5%
	Total	**62**	**100%**

The referred cases were sent mostly to the psychiatric ward (53%) as manic excitements were most common in this study and need inpatient care. The second most common mode was by Outpatient disposal (19%) followed by care under the same set up by either Physician or Surgeon who referred them, by giving proper advice and prescribing proper medication.

Table 10: Sex and Hospital distribution of suicide attempted case

Sex	IP	OP	Emergency	Total	Percentage
Male	119	3	2	124	53.7%
Female	105	0	2	107	46.3%
Total	**224**	**3**	**4**	**231**	**100.0%**

Table 11: Age distribution among suicidal attempts

S. No	Age Group (Years)	Male	Female	Total
1	15-20	24	8	32
2	21-50	93	96	189
3	>50	7	3	10
	Total	**124**	**107**	**231**

Out of 231 cases, referred males were slightly more than females. Most of the attempts were in the age group of 21 to 30 years in both males and females. The least age in suicidal attempt case was 15 years in male, and highest age was 74 years male. Below 20 years more males (24) are attempted than females (8), and 32 cases reported below 20 years of age. Least attempts seen in 51-60 years (3) and a slight increase (7) after 60 years.

Table 12: Suicidal attempts associated with psychiatric illness

S.No.	Suicidal attempts	Males	Female	Total
1	Attempts associate with psychiatric illness	23	28	51(22.1%)
2	Others(intentional, accidental etc)	101	79	180(77.9%)
	Total	**124**	**107**	**231(100.0%)**

As the psychiatric diagnosis of patients reviewed, most of them have attempted impulsively after a conflict with their family members and did not have a psychiatric diagnosis. 22.1% of cases were associated with psychiatric illness, where 18 (64.2%) out of 28 female cases had Mild to Severe Depression, Eight patients had Neurotic, Stress-related and Somatoform Disorders and 15 out of 23 males had Depression and three cases were having Substance-related diagnosis varying from harmful Alcohol Use to Alcohol Dependence, one case of Paranoid Schizophrenia and Four cases of Adjustment Disorder. Out of 61 cases, Depression observed in 14.2% of total attempts.

IV. Discussion

Males (55.7%) were more than females (44.3%), ranging from 4 years to 80 years. The findings are on par with a study done by Narayana Keertish et al. (58% and 42% respectively)[2]. 73.2% belong to 21-50 years age group. Paediatric age group was the least referred group (3.3%). Even the age group >60 years was low (5.3%). The reason could be a lack of awareness of psychiatric morbidity in old age among clinicians, family neglect and lesser life expectancy.

Most of the patients had primary education. Only 28% of cases were illiterates. The literacy rate is critical as it plays an important role in follow up psychiatric care.[3]

Diagnoses made by a Psychiatrist

The most common diagnosis found in the referral cases were impulsive suicidal attempts where attempted more after a conflict with family members or spouse. These were the cases routinely sent by physicians to psychiatry for counselling as a custom. Among the psychiatric illness mood disorders both in inpatients and outpatients take first place (18.1% and 30.7% excluding code X, Y, G) which was the same finding in previous studies like Sood A et al.[4], Sachdeva et al.[5] and Abhay K. De and PadmakaliKar.[6] In contrast with other Indian studies like Bhogale et al.[7] and Bhatia et al.[8] where neurotic, stress-related, somatoform disorders were a common diagnosis.

Diagnosis attempts and treatment by referring clinician

Only one-fifth of cases diagnosed of which around 50% given diagnosed appropriately. Treatment attempted in 11% of cases, and most of the non-psychiatrists used benzodiazepines in the referring patients before seen by a psychiatrist. In a study by Su JA et al., the overall accuracy of recognition of psychiatric illness was 41.5%, and there was no significant change during the five years period. Substance use disorders were the one diagnosis with the highest agreement, followed by delirium, depressive disorders, anxiety disorders, and psychotic disorders. As for the factors associated with accurate recognition, male patients or those with multiple physical illnesses were more likely to have their psychiatric symptoms recognised correctly.[9]

Mode of disposal

Single-visit and opinion was the most common mode of disposal. It could be due to most of the cases are referred for suicidal attempts/ideation, and most of them were done impulsively (64.8%), and they need cognitive, behaviour change and individual psychotherapy.

The most common diagnosis made by attending psychiatrist in the emergency unit was a mood disorder, followed by substance use disorders. Among mood disorders, manic excitements were more in number. This pattern is the same as that of previous studies where mood disorder was 40%, of which manic excitement was 56.25%. In contradicting to study by some Indian studies, Kelkar et al. (1982)[10] on emergency referrals have also reported neurosis as the most common psychiatric diagnosis. Another emergency study by Saddichha S [11] had suicidal attempts as the most common reason. In the present study, suicidal reason constituted only 6.5%. Western studies have a number of substance-related disorders in emergency[12,13,14]. When the attending clinician's diagnosis is analyzed, it showed psychosis was the most common diagnosis, which is a vague term commonly used among the general population. Psychosis is the third joint presentation during the study, not the first.

Females have psychiatric illness more of mood disorders followed by neurotic, stress-related and somatoform disorders and males are having a significant number of substance-related disorders followed by mood disorders seen by following study by Bruffaerts R[15]

Out of 62 cases referred, only 12.9% of cases given treatment which is far less than the United States where it is 61%.[16] In this study, the treatment given by the attending clinician

n was minimal. The findings show the emergency room personnel are not trained well in managing psychiatric cases until the duty psychiatrist attend the cases. Significantly mood disorders of which manic excitements were more in this study and four suicidal cases. These need immediate attention to calm down. It is essential to prevent harm to the patient and others in an emergency.

The referred emergency cases were disposed of mostly by transferring to the psychiatric ward as manic excitements were most common in this study and need inpatient care which is more than in a study by Ohaeri (Inpatient admission only 19.5%).[17] In Padilha study, 31.6% of the patients were referred to healthcare centres and 29.2% to specialized outpatient clinics, while 8.2% hospitalized.[18]

V. Conclusions

1. Mood disorders are a common psychiatric illness observed. Major Depressive Episode is frequent among mood disorders, which has to be recognised early and intervened.
2. Manic excitements frequently are seen in emergencies where the emergency staffs need training in understanding the patients and managing violent behaviours.
3. Suicidal attempt and Deliberate self-harm commonly referred reason
4. Emergency psychiatric cases are most often needed inpatient care in the psychiatry department.

LIMITATIONS :

1. Referral rate may not be accurate as all cases coming to the hospital who are having psychiatric illness may not be referred due to clinician lack of time and awareness of psychiatric symptoms, prior discharges, stigma among patients and family members regarding consulting psychiatrist.
2. Psychiatric illness may be diagnosed less when the patients do not reveal all the facts.
3. As the patients come from the surrounding districts, the results obtained cannot apply to every hospital setting in general.

References

[1]. SR Parkar, NS Sawant Review Article: Liaison psychiatry and Indian research.Indian Journal of Psychiatry, Year 2010, Volume 52, Issue 7 [p. 386-388]

[2]. Narayana Keertish, M.T. Sathyanarayana, B.G. Hemanth Kumar, Nitesh Singh and Kaveri Udagave. Pattern of Psychiatric Referrals in a Tertiary Care Teaching Hospital in Southern India. ClinDiagn Res. Aug 2013; 7(8): 1689–1691.

[3]. Ehrenreich MJ, Robinson CT, Glovinsky DB, Dixon LB, Medoff DR, Himelhoch SS. Medical inpatients adherence to outpatient psychiatric aftercare: a prospective study of patients evaluated by an inpatient consultation liaison psychiatry service. Int J Psychiatry Med. 2012;44(1):1-15.

[4]. Sood A, Singh P, Gargi PD. Psychiatric morbidity in non-psychiatric geriatric inpatients. Indian J Psychiatry. 2006 Jan;48(1):56-61.

[5]. Sachdeva JS, Shergill CS, Sidhu BS. Prevalence of psychiatric morbidity among medical in-patients. Indian J Psychiatry. 1986;28:293–6

[6]. De AK, Kar P. Psychiatric disorders in medical in-patients - a study in a teaching hospital. Indian J Psychiatry. 1998 Jan;40(1):73-8.

[7]. Bhogale GS, Katte RM, Heble SP, Sinha UK, Patil PA. Psychiatric referrals in multi-speciality hospital. Indian J Psychiatry 2000;42:188-94.

[8]. Bhatia MS, Balakrishna NK, Dhar, Bohra N, Gupta H. Psychiatric morbidity in patients attending medical OPD. Indian J Psychiatry. 1987;29:243–6.

[9]. Su JA, Tsai CS, Hung TH, Chou SY Change in accuracy of recognizing psychiatric disorders by non-psychiatric physicians: five-year data from a psychiatric consultation-liaison service. Psychiatry Clin Neurosci. 2011 Dec;65(7):618-23.

[10]. Jain V, Singh H, Gupta SC, Kumar S. A study of hopelessness, suicidal intent and depression in cases of attempted suicide. Indian J Psychiatry 1999;41:122-30.

[11]. Saddichha S, Vibha P, Saxena MK, Methuku M. Behavioral emergencies in India: a population based epidemiological study. Soc Psychiatry Psychiatr Epidemiol. 2010 May;45(5):589-93.

[12]. Padilha VM, Schettini CS, Santos Junior A, Azevedo RC. Profile of patients attended as psychiatric emergencies at a university general hospital.Sao Paulo Med J. 2013;131(6):398.

[13]. S Kropp, C Andreis, **et al.**Characteristics of psychiatric patients in the accident and emergency department (ED)].Psychiatr Prax 34 (2), 72-5, 2007.

[14]. Larkin GL, Claassen CA, Emond JA, Pelletier AJ, Camargo CA. Trends in U.S. emergency department visits for mental health conditions, 1992 to 2001. Psychiatr Serv. 2005 Jun;56(6):671-7.

[15]. Bruffaert R. etal. Attenders of a university hospital psychiatric emergency service in Belgium - general characteristics and gender differences. Soc Psychiatry Psychiatr Epidemiol. 2004 Feb;39(2):146-53.

[16]. Larkin GL, Claassen CA, Emond JA, Pelletier AJ, Camargo CA. Trends in U.S. emergency department visits for mental health conditions, 1992 to 2001. Psychiatr Serv. 2005 Jun;56(6):671-7.

[17]. Ohaeri JU, Adeyemi JD. Psychiatric emergencies in a Nigerian general hospital. East Afr Med J. 1989 Nov;66(11):769-75.

[18]. Padilha VM, Schettini CS, Santos Junior A, Azevedo RC. Profile of patients attended as psychiatric emergencies at a university general hospital.Sao Paulo Med J. 2013;131(6):398.

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