PSYCHIATRIC REFERRALS IN THE GENERAL HOSPITAL

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ABSTRACT

Psychiatric disorders and physical illnesses often coexist. Although there is evidence of high psychiatric morbidity in general hospital patients, only a small percentage are referred to the consultation-liaison psychiatrist. The paper describes and discusses the common psychiatric conditions encountered and referred in general hospitals. They include attempted suicides, psychiatric disorders presenting with physical symptoms, organic psychiatric disorders presenting with psychiatric symptoms and the psychiatric consequences of physical illness. The major diagnostic categories of these referrrals are organic psychotic disorders, functional psychoses and neurotic disorders.

Some broad guidelines are listed for the referring physician. Patients presenting with suicidal ideations or attempts, suspected emotional psychiatric disturbance, a history of psychiatric illness, an apparent incompetence in giving consent for medical procedures and those with diagnostic and management problems could be referred to the psychiatrist.

Keywords: *consultation-liaison psychiatry, general hospital, referrals, guidelines.*

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INTRODUCTION

It has been recognised that psychological factors can play a part in the aetiology, symptomatology and course of physical illnesses. Psychiatric disorders and physical illnesses commonly coexist in medical and surgical practice[1]. Hence, no clinical assessment is complete without consideration of the patient's emotional symptoms and psychosocial background.

Management of the more complicated cases has been made easier by the integration of psychiatric departments into general hospitals. Today, most general hospitals in the United Kingdom and North America have a psychiatric service, albeit varying in size and organisation. In Singapore, only two general hospitals – the National University Hospital and Tan Tock Seng Hospital have psychiatric departments. (NB: The University Department was formerly located at the Singapore General Hospital)

These departments usually provide both consultation and liaison services. The term "consultation and liaison psychiatry" refers to two different ways of conducting psychiatric work in a general hospital[2]. In consultation work, the psychiatrist is available to give an opinion on patients referred by physicians and surgeons. It is essentially patient-orientated.

In liaison work, he becomes a member of a medical or surgical team. He participates in ward rounds and clinical meetings for the purpose of teaching medical staff in identifying, managing and referring appropriately patients showing psychological and psychiatric problems. The psychiatrist also helps resolve conflicts amongst staff and sometimes between staff and patients. Today, most psychiatrists in general hospitals take on both consultation and liaison roles.

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COMMON PSYCHIATRIC PROBLEMS IN THE GENERAL HOSPITAL

Numerous studies have shown that the prevalence of psychiatric disorders is higher in general hospitals than in the community[1]. The psychiatric problems that are commonly encountered and referred can be grouped into the following:

1. Attempted suicides.
2. Psychiatric disorders presenting with physical symptoms.
3. Organic psychiatric disorders presenting with psychiatric symptoms.
4. Psychiatric consequences of physical illness.

Attempted suicides

Various studies have reported that between 35%[3,4] and 47%[5] of psychiatric referrals are for attempted suicides. Most are found to have relationship difficulties such as marital conflict. Thirty-one percent[6] to 40%[4] are diagnosed to have neurotic depression. Other diagnostic categories include personality disorder, schizophrenia, affective disorder and alcoholism. However, about 20% have no psychiatric illness[7].

For most suicide attempters there is no useful correlation between the medical severity of the episode and the patient's mental state. However, clinical experience suggests that acts which carry a high risk of fatality, such as jumping from a height, use of firearms, hanging or drowning, tend to be committed by patients suffering from severe mental illness. Hence, such patients should be referred to the psychiatrist for assessment.

It has been found that non-psychiatric staff such as social workers[8] and junior physicians[9] can be trained to screen patients with suicide attempts. In fact, their assessment findings correlate fairly well with that of psychiatrists with only about two-thirds requiring a subsequent referral to a psychiatrist[10].

Psychiatric disorders presenting with physical symptoms

Medically unexplained somatic symptoms such as pain, fatigue, giddiness, shortness of breath etc, often pose a diagnostic and management problem. They constitute about 30%[11] of psychiatric referrals. This group of patients usually have a history of "doctor shopping" and lengthy and expensive investigations. They make considerable demands on healthcare facilities.

Such patients would definitely benefit from an early psychiatric assessment. If psychiatric opinion is sought only after lengthy investigations, patients may perceive this as a last resort measure and would consequently reject the notion of a psychological basis to their symptoms.

Psychiatric evaluation of these patients reveals that most suffer from affective, somatoform and anxiety disorders[12,13]. Most of the affective disorders fall into the category of depression. The somatoform disorders include conversion disorder, hypochondriasis, somatoform disorder (Briquet's syndrome) and dysmorphophobia. Among the anxiety disorders are phobias and panic disorders in which case the somatic symptoms are intermittent.

Factitious disorders eg Munchausen's syndrome, is another group whereby patients present with somatic symptoms that are deliberately fabricated. Assessment and management of these patients are often difficult especially when they coexist with genuine physical problems.

The presentation of psychiatric disorders with physical symptoms has come to be known as somatisation. Somatisation is also influenced by social and cultural factors. For instance, it has been found that the Chinese tend to report more somatic rather than emotional symptoms when psychologically disturbed.

However, it is imperative that the diagnosis of psychiatric illness should always be made on positive criteria and not merely on exclusion of organic pathology. In some cases, the passage of time and re-examination will reveal physical pathology which had not been evident at the initial assessment.

Organic psychiatric disorders presenting with psychiatric symptoms

Organic psychiatric disorders refer to psychiatric disorders that are caused by coarse brain disease or disease outside the brain, such as myxoedema. They nearly always present with cognitive impairment but a small proportion have disturbances in mood, perception and thinking. Their clinical manifestations could be classified under three main groups:

a. *Delirium*

The most important clinical feature in delirium is impairment of consciousness, which varies in intensity throughout the day and is usually worse in the night. The patient is disorientated for time and place and there is impairment in thinking, attention, memory and perception. There is also a range of psychomotor disturbances ranging from stupor to ceaseless restlessness.

b. *Dementia*

This is a clinical syndrome where there is generalised impairment of intellect, memory and personality but in the absence of impairment of consciousness. The onset is usually insidious and may be mistaken for depression or normal changes in the ageing process.

c. *Specific psychological impairment*

This may take the form of a specific impairment of memory, thinking, perception or mood. It includes those with affective and schizophrenic-like symptoms.

Some of the causes of organic psychiatric disorders are shown in Table I.

Recognition of organic psychiatric disorders has major practical implications. Mistakes in the differential diagnosis of organic and affective disorders and the misdiagnosis of dementia may result in inappropriate treatment. Early identification of delirium is essential as it may be life-threatening requiring immediate treatment of the underlying physical condition. Delirious patients being often agitated can also be difficult to manage, but appropriate psychiatric treatment is usually effective.

Table I – Causes of Organic Psychiatric Disorders

i. Intracranial Causes	
Degenerative	Alzheimer's disease, Huntington's chorea, Parkinson's disease, normal pressure hydrocephalus
Trauma	repeated head injury as in boxers, severe single head injury
Vascular	cerebral haemorrhage, subarachnoid haemorrhage, subdural haemorrhage, systemic lupus erythematosus
Epilepsy	pre-ictal aura, psychomotor seizure, post-ictal state
Infection	encephalitis, cerebral abscess, meningitis, AIDS
Tumour	primary or secondary
ii. Extracranial Causes	
Trauma	hypothermia, fat embolism, cataract surgery, open heart surgery
Infection	septicaemia, pneumonia, urinary infection
Toxic	alcohol, therapeutic drugs eg anticholinergics, L dopa and corticosteroids
Endocrine	hypo- and hyperthyroidism, hypoglycaemia, hypo- and hyperparathyroidism, Addisonian crisis, hypopituitarism
Metabolic	uremia, liver failure, electrolyte imbalance, porphyria
Hypoxia	respiratory failure, cardiac failure, acute heart block, carbon monoxide poisoning
Neoplasms	especially of bronchus and pancreas
Vitamin Deficiency	thiamine, B_{12}, folic acid

Psychiatric consequences of physical illness

Most people who become physically ill have to make some degree of psychological adjustment. The patient's perception of the illness, his premorbid personality, coping style and social factors will influence how well he copes and adjusts.

Certain illnesses such as haematological cancer, ischaemic heart and chest diseases are especially associated with higher psychiatric morbidity[14].

In the physically ill, the most common psychiatric disorders are emotional disorders, which occur in 13-61% of in-patients[1]. The majority are diagnosed as adjustment disorders but specific anxiety and affective disorders are also common. Anxiety is more common with acute physical illness, depression with chronic physical illness. It is important to recognise these disorders as they can complicate management of the physical illness.

A survey of psychiatric disorders in medical in-patients revealed that anxiety and depression are strongly associated with past psychiatric history, current social problems and the taking of psychotropic medication including hypnotics[1]. It was suggested that this group of patients be routinely screened for mood disorders.

Occasionally, a physical illness may induce a psychosis, either an affective disorder (both mania and depression) or a schizophrenic-like condition.

A small proportion of patients may develop an acute paranoid reaction which takes the form of a brief psychosis. Suspicion and

resentment are directed towards the staff. Here, there is no impairment of consciousness and cognitive functions are grossly intact. Some may have had a previous psychiatric illness and there is usually social or sensory isolation eg severe bilateral deafness[15].

Similiar effects can also be induced by the drugs used to treat physical disorders eg corticosteroids can cause psychotic and affective symptoms.

PSYCHIATRIC DIAGNOSIS

Table II shows the type of psychiatric disorders that are typically referred to psychiatric departments in general hospitals. Three hospitals namely, Singapore General Hospital, Tan Tock Seng Hospital and Guy's Hospital, London, are compared.

Table II – A comparison of the diagnoses of 3 psychiatric departments

Diagnostic category	SGH[3] %	TTSH[4] %	UK[5] %
Organic psychotic disorders	18.9	22	19
Functional psychoses	21.1	29.7	7
Neurotic disorders	37.4	27.2	47
Others	22.6	21.1	27
Total	100	100	100

The "organic psychotic disorders" include delirium, dementia, hyperthyroidism, alcoholic psychosis, systemic lupus erythematosus (SLE) and psychosis associated with epilepsy.

"Functional psychoses" include schizophrenia and affective and paranoid disorders.

"Neurotic disorders" consist mainly of anxiety neurosis and neurotic depression. The rest are hysteria, obsessive compulsive neurosis and phobic states.

"Others" include personality disorders, alcoholism and mental retardation.

The types of referrals seen in the two Singaporean hospitals are basically similar. In contrast, Guy's Hospital sees less of functional psychoses but more of neuroses. The referral pattern mainly depends on the catchment patient population that the psychiatric department serves.

Reasons and guidelines for referral

The physician must be able to ascertain the precise reason for any referral. There are some broad guidelines. A patient may be referred for a psychiatric opinion for the following reasons:

a. When he has attempted suicide or has hinted suicide during the course of medical treatment.

b. When he is a management problem. This includes the aggressive, violent, manipulative, hostile, demanding and non-compliant patient.

c. When he poses a diagnostic problem. This usually occurs when the patient presents mainly with persistent medically unexplained somatic symptoms.

d. When he is thought to be suffering from an emotional disturbance or a psychiatric disorder which may or may not be related to the physical disorder and its treatment.

e. When he has a history of psychiatric illness and is admitted for a medical or surgical problem eg a patient with schizophrenia who is admitted for a physical injury and is referred for continuation of psychiatric care.

f. When he does not seem competent to manage his own affairs or give consent for medical procedures.

g. When he or his relatives request to see a psychiatrist. This is not a common occurrence.

Reasons against a psychiatric referral

The belief that patients dislike being referred to psychiatrists, the stigma of being labelled a psychiatric case, the perception that psychiatric treatment is ineffective and dissatisfaction with psychiatric services are some reasons why physicians decide against a psychiatric referral[16].

Rates of referral

The rates of referral of general hospital in-patients for psychiatric opinion vary from less than 1%[17] to 9%[18]. The rates appear to be related to the degree of development of the consultation services in the hospital and the closeness of the links between the psychiatrist and his medical colleagues. It also depends on the ability of the medical staff to recognise psychiatric disorders.

CONCLUSION

Psychiatric morbidity is common in general hospitals. Consequently, there is a need for the general medical staff to be aware of the psychiatric disorders that are present in the physically ill. Early detection and referral of psychological and psychiatric disorders to the psychiatrist alleviates unnecessary suffering and hastens the recovery process. It also allows for a more comprehensive management strategy. In the long term, it prevents wastage of medical resources.

References

1. Mayou R, Hawton K. Psychiatric disorder in the general hospital. Br J Psychiatry 1986; 149: 172-90.
2. Lipowski ZJ. Current trends in consultation-liaison psychiatry. Can J Psychiatry 1983; 28: 329-37.
3. Tsoi WF, Kok LP. Liaison psychiatry – referral pattern in a general hospital. Singapore Med J 1983; 24: 268-76.
4. Peh LH, Tay WK. Psychiatric referral pattern in a general hospital. SingaporeMed J 1990; 31:42-5.
5. Anstee BH. The pattern of psychiatric referrals in a general hospital. Br J Psychiatry 1972; 120: 631-4.
6. Newton-Smith JGB, Hirsch SR. Psychiatric symptoms in self-poisoning patients. Psychological Med 1979; 9:493-500.
7. Kessel N. Self-poisoning. Br Med J 1965; 2:1265-70.
8. Newton-Smith JGB, Hirsch SR. A comparison of social workers and psychiatrists in evaluating parasuicide. Br J Psychiatry 1979; 134: 333-42.
9. Gardner R, Hanka R, O'Brien VC, Page AJF, Rees R. Psychological and social evaluation in cases of deliberate self-poisoning admitted to a general hospital. Br Med J 1978; 2:1567-70.
10. Gardner R, Hanka R, Evison B, Mountford PM, O'Brien VC, Roberts SJ. Consultation-liaison scheme for self-poisoned patients in a general hospital. Br Med J 1978; 2:1392-4.
11. Thomas CJ. Referrals to a British liaison psychiatry service. Health Trends 1983; 15:61-4.
12. Katon W, Ries RK, Kleiman A. A prospective DSM-III study of 100 somatization patients. Compr Psychiatry 1984; Part II 25: 305-14.
13. Lloyd GG. Psychiatric syndromes with a somatic presentation. J Psychosomatic Research 1986; 30: 113-20.
14. Feldman E, Mayou R, Hawton K, Arden M, Smith EBO. Psychiatric disorder in medical in-patients. Q J Med 1987 New Series 63; 241:405-12.
15. Cutting J. Physical illness and psychosis. Br J Psychiatry 1980; 136: 109-19.
16. Mezey AG, Kellett JM. Reasons against referral to the psychiatrist. Postgrad Med J 1971; 47:315-9.
17. Wallen J, Pincus HA, Goldman HH, Marcus SE. Consultations in short-term general hospitals. Arch Gen Psychiatry 1987; 44:163-9.
18. Lipowski ZJ. Review of consultation psychiatry and psychosomatic medicine. Psychosomatic Med 1967; 29: 201-10.