



A study of liaison psychiatry referrals in a Zambian Teaching Hospital

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Abstract

Aim of our study was to assess the referrals to the Department of Psychiatry in the University Teaching Hospital Zambia (UTH) and to suggest improvements that will improve the efficiency of the liaison psychiatry service. All referrals to psychiatry over a period of five months at UTH were reviewed and assessed. The literature pertaining to the topic was reviewed. A total of 86 referrals were made to the Department of Psychiatry over the five-month period. The highest rate of referrals came from internal medicine (52.3%) followed by surgery (18.5%). 3.5% were from obstetrics/gynaecology and 2.3% from paediatrics. Psychosis and substance misuse were the commonest reasons for referral. Only about a third of the referrals indicated the urgency of the referral or showed the diagnosis made by the Consultant Psychiatrist. Most of the referrals seem to have been made appropriately to psychiatry, which is encouraging. However, improvements can be achieved. It should firstly be ensured that all sections of the referral form are fully completed. Secondly, the referral form can be re-designed to provide more details. Thirdly, the information in the forms should be accessible separately and within case notes. Also, considering the number of alcohol withdrawal cases, a hospital-wide protocol should be considered so that acute alcohol withdrawal need not be routinely referred for psychiatric assessment.

Key Words: Consultation liaison psychiatry, referrals, teaching hospital

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Introduction

Liaison psychiatry operates at the interface of psychiatry and medicine offering psychiatric assessment and treatment to patients with interweaving medical and psychiatric problems. This branch of medicine is especially essential in a country such as Zambia where specialist psychiatric resources are very scarce and medical morbidity quite high. Moreover, given that psychiatric training is often absent or inadequate, the medical workforce often lacks the necessary skills and knowledge to

manage psychiatric problems presenting to general hospitals [1]. As a result, many patients with comorbid medical and psychiatric illnesses may be mismanaged or simply fall through the radar [2]. Good liaison psychiatry is needed to see that patients receive care for their psychiatric and medical symptoms holistically, especially in a low resource setting [3].

This issue is not unique to low resource settings and the need for specialist liaison services is now being widely recognized with new schemes e.g. RAID (Rapid Assessment Interface and Discharge) being set up (in the UK) to improve liaison psychiatry services. RAID has been evaluated as a success, particularly in reducing hospital bed duration and in reducing readmission rates by 60% saving money and improving patient experience [4].

Despite the importance of liaison psychiatry, there are very few studies of referral patterns in Africa. This dearth causes problems in evaluating the need for (and the benefit of) liaison psychiatry services in the African context. This study is the first

such one in Zambia assessing the pattern of liaison referrals to the Department of Psychiatry at University Teaching Hospital (UTH) in Lusaka. The study was carried out to evaluate the sources and reasons for referral and to understand the lessons that can be learned from the referral pattern.

Methods

This was a descriptive cross sectional study conducted at UTH in Lusaka, Zambia. UTH is the largest hospital in Zambia and the main training base for doctors, nurses and clinical officers. It has approximately 1655 beds, provides for all primary, secondary and tertiary needs and also caters to specialist referrals from across the country. This study analyzed 86 referral forms to the psychiatry department made over five months from January to May 2015. The data obtained were the source of referral, the urgency, the presentation and the consultant diagnosis. These results were analyzed using descriptive statistical methods and tabulated in a spreadsheet. The presentations were also categorized into seven categories: substance misuse, psychosis, depression/mood disorder, confusion/agitation, self harm, anxiety/distress and others.

Results

In total, 86 patients were referred to the psychiatric department during the study period. This equates to a referral rate of approximately 1% of the total number of beds per year. The most common source of referral was medicine (52.3%). Surgery (18.5%) and orthopaedics (12.8%) were also significant. 5.8% came from a 'physician', obstetrics/gynaecology, 3.5% and paediatrics, 2.3%. The eye ward, maternity ward, outpatient clinic and 'unmarked' all represented 1.2%. This was expected; the pattern is echoed in studies in Nigeria and India, with medicine being the most common, surgery second and obstetrics/gynaecology last [2, 5].

The most prevalent presentation category was psychosis (26.4%), closely followed by substance misuse (22.0%). Confusion accounted for 19.9%, depression/mood disorder for 13.2% while self-harm (6.6%) and anxiety/distress (3.3%) were fairly low. There was no specific field for a known psychiatric patient, but forms stating patients had a known or previous psychiatric history amounted to 16.3%. Forms which mentioned a medical problem or reason for admission constituted 29.1%. Out of these,

23.1% were due to alcohol withdrawal, 4.0% due to opioid withdrawal, 16.0% due to burns and 12% due to fractures, which may be the consequence of alcohol intoxication as indicated in some forms.

Psychiatric consultation was therefore sought for varied reasons, including schizophrenia, irrelevant talking, post traumatic stress and 'mental dysfunction'.

Discussion

This study was conducted in the largest hospital in Zambia. The referral rate was 1.0% per bed per year. This low figure is shown in other developing countries, for example India.⁵ In contrast, the referral rate found in Guy's Hospital, London was 97.5% per bed per year [6]. This study's referral rate may seem very low but it is in line with figures reported in other developing countries and may indicate the low detection rate of psychiatric illness in routine medical practice in acute hospitals. This is not surprising given the paucity of mental health training [7].

The primary reason for referral was psychosis, which was high at 26.4%. This was positive - more psychosis incidents are being picked up, especially as a co-morbid psychiatric condition. However, it could also be indicative of a psychotic relapse in stable patients following admission to acute hospitals either due to increased stress or to discontinuation of their antipsychotics. High referral rates for psychosis may also indicate the use of the label "psychosis" as an umbrella term for 'abnormal behaviour' or 'irrelevant talking'. In similar income countries, the most common reason for referral was either somatic symptoms [5, 8] or the presence of psychiatric symptoms [2]. This could be further indicative of psychosis being given as the broad reason for medically unexplained symptoms.

There were very few referrals due to anxiety, which may have been categorized as psychosis due to 'muteness' or 'unresponsive behaviour'. Ndeti and al have put forward the argument that psychosis is too broad a diagnosis and that measures should be taken to cultivate well-defined referrals and diagnoses to provide better treatment and assessment [9].

On the other hand, Thornhill and Tong have argued that training needs to focus on recognition of psychosis or of psychiatric symptoms and referral to

appropriate psychiatric services rather than on achieving diagnostic precision [10]. They are supportive of categorizing symptoms to make referral easier, which can be done with a symptom based referral form (explained below.)

The second highest reason for referral was substance misuse. This is not surprising - Zambia has higher levels of alcohol misuse and dependence compared to the WHO Africa Region average [11]. Acute alcohol withdrawal with its attendant risk of delirium tremens can present a medical or psychiatric emergency and may require hospital admission to the general medical unit. More commonly, patients admitted for unrelated medical conditions may suffer acute withdrawal, triggering a psychiatric referral. Given the volume of referrals, the UTH psychiatric team tends to provide a service for acute alcohol withdrawals but is unable to provide a relapse prevention or rehabilitation programme.

In the UK, acute alcohol withdrawal management is protocol-driven and is often managed without the support of the psychiatry team. Senior nurses, trainees and consultants of all specialties can treat alcohol withdrawal using a standardised protocol, treating it as a medical problem and utilising the liaison psychiatry referral for rehabilitation and outpatient (or inpatient) appointments to sustain abstinence or controlled drinking. NICE (National Institute of Health and Care Excellence) provides a detailed protocol listing the care pathway for managing acute alcohol withdrawal and this should be easily adaptable for the Zambian context [12].

Referrals from obstetrics/gynaecology were very low, at just three out of 86. As explained by Ajiboye, obstetrics/gynaecology patients are much less likely to be referred unless they manifest acute or exaggerated psychotic symptoms [2]. In this study, the three patients referred were so due to psychosis or irrational behaviour. This concurs with findings in a study at UTH, in which antenatal depression rates were found to be quite high but did not trigger a referral [17].

Referrals due to self harm were very low (6.6%). This low figure was seen also in a study in a Nigerian teaching hospital [2] (6.3%), and even lower in a Southern Indian hospital [5] (1.4%). Yet in developed countries this figure remains much higher, frequently cited as the principal reason for referral [4]. This difference in figures could be explained by

the higher stigma placed on self-harm in developing countries. Self harm may not always be recognized in hospitals or emergency departments due to insufficient training and indeed many with self harm may not even come into hospital due to family or community pressure or to personal belief. Timely and comprehensive risk assessment can prevent further harm and can lead to signposting to appropriate treatment. Risk assessment tools do not have good validity in predicting risk but may help staff members assess risk in a consistent manner using simple checklists and can lead to more appropriate referrals to Psychiatry [13].

Another notable feature was the high number of referrals for acute confusional states. Given the low life expectancy in Zambia (58 years) [14], it was unsurprising that these were not related to dementia but to delirium secondary to the underlying medical condition. However, it was difficult to draw any specific conclusion with regards to the association between geriatric medical issues and confusion secondary to age-related conditions such as dementia as the referral form did not have a field for date of birth or age. It is also possible that some of the referrals were misdiagnosed substance misuse related problems despite a generally encouraging number of referrals for substance abuse.

In the aforementioned study in India, medically unexplained symptoms were the primary reason for referral [5]. Yet, in this study, medically unexplained absence of talking and walking in a patient was the only instance of such a referral. This could be explained by cultural differences in presentation and help-seeking, as has been shown in other lower income countries [8] but may also reflect poor recognition of somatic presentations of illnesses such as depression and anxiety, again a manifestation of sparse psychiatric training [7].

In the long-term, improving the quality of psychiatric training would benefit, but a more prosaic solution would be to have a revised referral form based on a checklist. The advantages of a simple checklist have been outlined by Gawande in his best-selling book [15]. An example of such a form is the one used by the West London Mental Health Trust [16]. This should allow psychiatrically untrained assessors to 'rate' or 'tick' the symptoms they see and based on the results, triage to management within their own units (for e.g. alcohol withdrawal or delirium) or refer to psychiatry (for e.g. agitated behaviour or suicidal behaviour). Refinements to

referrals should occur over time as referrers get feedback from the Department of Psychiatry about the appropriateness of their referrals.

At present, all patients were referred having first come into hospital for an acute medical problem, yet this primary condition is not stated on the referral form. Just 29.1% of physical medical conditions were stated, and all were not specifically stated as the reason for hospital admission. For the psychiatric assessor, knowledge of the patients' current diagnoses and medical treatment is necessary to enable appropriate assessment and management.

Another area of improvement would be to ensure the 'urgency' field is completed and qualified. Qualifying urgency to identify those who need intervention within the hour (e.g. acutely violent patients) in contrast to those who need intervention within the week (e.g. social distress) would allow scarce resources to be targeted more efficiently and could have a significant impact on patient safety.

The psychiatric assessment (including the diagnosis and management plan) needs to be recorded on the structured assessment form currently being used in the Department and filed within the Departmental records. This is important in terms of auditing and evaluating outcomes, to ensure that referrals are appropriate and to maintain continuity of care for patients.

This does lead to the problem of double data entry as assessment data and management plans also need to be recorded in the acute health care records. This problem is universal as has been highlighted by Maudsley and Guy's Hospital, London.⁶ A practical solution is for the psychiatric assessor to record brief notes in each patient's acute hospital files.

Following the same principle, a "previous psychiatric history" field should also be included on the referral form. This should enable psychiatric staff to quickly cross-reference with their own records to identify patients under their care. The outcome of the referral should be recorded (for example, admission, new treatment, further follow-up). Including space on the form to indicate whether the patient is aware of the referral, whether they consented, and if the next of kin is aware is also important.

In summary, a referral form providing a checklist of symptoms and behaviours to provide a reason for referral; important demographic

information viz. patient's age/gender/ethnicity; current medical condition; any known psychiatric condition; current treatment along with a structured history, mental state examination and risk assessment form and finally an indication of the urgency of the referral should improve the pathway of liaison referrals at UTH. Filing these referrals along with the detailed assessments within the Department of Psychiatry at UTH should improve the continuity of care. The patients' reason for referral, personal information, symptoms, diagnosis and follow up would be in one place, available for professional review, for audits and for evaluations.

The limitations of this study must be acknowledged. It was conducted in one hospital, however consideration must be given to the fact that it is the only hospital in Zambia with a liaison psychiatry service. 86 referral forms were evaluated, which is relatively a small number but it does represent the bulk of referrals made in the calendar year (January to May).

Conclusion

This is the first study of liaison psychiatry referrals in Zambia. Despite the lack of extensive psychiatric training, referrals are largely made appropriately which is encouraging. However, the efficiency of the liaison psychiatry service can be further improved. The study would recommend:

- Referrers be sensitised to the importance of completing referral forms
- Update the psychiatry referral form to include a qualified urgency field, sex, date of birth, medication, physical symptoms, previous psychiatric history, detailed reason for referral, source of referral, reason for admission and outcomes
- Develop a symptom-based checklist for the reason for referral
- Store all referral forms together for audit and continuity purposes, however the psychiatry assessor should make brief notes within patients' acute hospital notes
- Develop a protocol to treat acute alcohol withdrawal as a general medical condition, for use of all hospital-based staff avoiding unnecessary referral to psychiatry.

The impact of any changes will need to be evaluated by conducting further studies to gather

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more data to elucidate the pattern of referrals and the impact on patient outcomes.

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