A COMPARISON OF PSYCHIATRIC REFERRALS WITHIN THE TEACHING HOSPITAL WITH THOSE FROM PRIMARY CARE AND GENERAL HOSPITALS IN SAUDI ARABIA

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Objective: This study aims at examining the pattern of psychiatric referrals with particular reference to (1) age and gender (2) source of referrals and (3) diagnosis of referred patients within a teaching hospital.

Method: Four hundred and twenty seven referrals (n=427) for psychiatric consultation within KKUH were selected prospectively by systematic randomization over a period of one year, and were compared with a general hospital (n=138) and primary health care (n=402) psychiatric referrals to a mental health facility.

Results: The age of referred patients across the three settings differed significantly and the male patients were slightly over-represented in the teaching hospital.
referrals. Pediatric clinics in the teaching hospital constituted significant sources of psychiatric referrals as compared to the general hospitals. Schizophrenic disorders and acute psychoses were significantly less among teaching hospital referred patients, whereas anxiety and mood disorders were much more common among teaching hospital and primary care patients. The number of personality disorders diagnosed in teaching hospital settings was significant.

Conclusions: In Saudi Arabia, sources of psychiatric referrals and diagnostic patterns of mental disorders differ across the three levels, and this is comparable to international research on psychiatric referrals. Besides exploring other aspects of referral process, researchers at the three settings should carry out follow-up studies to assess the impact of psychiatric consultations on the global outcome of referred consultees.

Key Words: Psychiatric referrals, primary care, general hospitals, teaching hospital, diagnostic pattern, psychiatric consultations, referred consultees, mental health facility.

INTRODUCTION
Primarily, the referral system or consultation-liaison consisted mainly of three interrelated and integrated components. They are the referring physician/consultant, patient and the consultant the patient is referred to. The dynamic process of referring a patient is triggered by various related reasons including the deficient skills of the referring physician/consultant, diagnostic and therapeutic conundrums of the patient, and the greater expertise of the consultant to whom the patient is referred.¹ The success of referral system requires, inter alia, close collaboration, meaningful discussion and communication among health providers and consumers, clearly specified objectives by the referring physician and a comprehensive interview of the patient and a comprehensive interview of the patient coupled with a feedback by the consultant.² However, as in primary health care (PHC), there is evidence that both the general and teaching hospital population with or without medical diseases suffer from a number of psychiatric disorders, somatic symptoms, sub-threshold conditions, and comorbid disorders and, therefore, require psychiatric-consultation liaison services.³,⁴ Further, the reported prevalence of psychiatric morbidity and comorbidity in the general hospital (GH) population is certainly higher (up to 84%), than the PHC patients (20-50%).⁵-⁸ Moreover, the referral rate within the GH and teaching hospital (TH) settings varies between 0.7% to 23%⁹-¹⁰ attributable to different referral sources,¹¹ sociodemographic and clinical characteristics of the patients, and the skills of the referring clinicians.¹²,¹³-¹⁴

To the author’s knowledge, only one descriptive study with a small sample (n=97)¹⁵ has explored the pattern of psychiatric consultations in a university TH in the Arab Gulf countries. Therefore, the present study aims to examine the sociodemographic parameters-age and gender, sources of psychiatric referrals, and the diagnostic patterns of psychiatric disorders among referred patients within a TH as compared with psychiatric referrals from GHs and primary health care centers (PHCCs) to the Buraidah Mental Health Hospital (BMHH). The main reason for
addressing only those three issues was that the information related to these items on the referral forms was readily obtainable and fairly reliable.

Based on previous clinical experience and extensive review of relevant literature, the author hypothesizes, (i) there would be age- and gender-divergent differences among TH, GHs and PHC referred patients, (ii) the sources of referrals in a TH would be more diverse than the GHs and PHCC; (iii) the diagnostic pattern in the TH would be more varied and complex than the GHs and PHCC. The findings of this study may lead to an improvement in the psychiatric consultation-liaison services in THs, and the development of similar services in GHs and PHC not only in the Kingdom of Saudi Arabia (KSA) but also in other Gulf countries.

MATERIAL AND METHODS

Teaching Hospital, GH, AND PHC Samples
King Khalid University Hospital, a 834-bed tertiary care hospital with almost all specialty departments, offers outpatient and inpatient health services to clients referred from all over the KSA. The TH sample, restricted to psychiatric consultations sought within this hospital, comprised patient referral forms (n=427), which were selected randomly, every third to the psychiatry clinic, by a trained nurse over a period of one year from June 1999 to June 2000. Conventionally, the referral form of each referred patient for psychiatric consultation together with feedback report is appended to the patient's file. The noted data in the selected referral forms were photocopied. Notably, TH consultant psychiatrists and BMHH psychiatric specialists use mainly the DSM-IV16 for diagnostic purpose, though they had a broad knowledge of the ICD-10.17 The final diagnoses made by the consultant psychiatrists in the TH and psychiatric specialists in the BMHH were considered in this research. These diagnoses were made in accordance to the DSM-IV criteria at both settings. Despite the use of similar diagnostic criteria at the two settings, the reliability and validity of these diagnoses needing different investigations is questionable, an obvious limitation of the methodology of this study.

The randomly selected psychiatric referral letters of patients (n=540) referred from GHs (n=138) and PHCCs (n=402) of Al-Qassim area to BMHH, the details of which are described elsewhere, would be used for comparison with the TH sample. The BMHH was selected because it is located in a semi-urban area with many different health facilities, representing different sections of the population in the KSA and a good source of referral.

Patient Referral Form, KKUH
Only one type of patient referral form was used in KKUH. This contained several items, in three categories, (i) “patient referred from” including: name of referring physician, status, clinic/ward, (ii) “patient referred to” and this included: name of consulted physician, status, clinic/ward, and finally (iii) “details about the patient” including patient’s name, file number, age, sex, marital status, occupation, whether the referral was urgent or elective, the presenting complaint, history of present illness, past history, current drugs taken, allergy if any, physical examination, provisional diagnosis, reason of referral, signature of referring physician, date, and the investigations undertaken. There are about 24 items on the referral form and the referring physicians are expected to complete all items with the relevant information.
Like the TH referral form, PHCCs referral forms had similar items, but with a few differences (1) the item 'name of referred consultant' was present only in TH and GH referral forms (2) the items 'patient's education, marital status, and allergy' were present only in TH referrals and (3) items 'patient's address and official and doctors’ stamp' were not on TH referral form. Notably, GHs, private hospitals, and clinics, referring mental patients to BMHH, also used referral letters with various items.

STATISTICAL ANALYSIS
The data on the TH referral letters were entered into the computer. Besides frequency analysis, both Chi-square and t-tests were also used as appropriate. The Statistical Package for Social Sciences (SPSS) 10.0 program for windows was used. The p-value of 0.05 or less was considered significant.

RESULTS
The mean age of patients referred from GHs (31.53 ±18.14) and PHCCs (30.32 ±18.69) was significantly higher than the mean age of TH patients (25.99 ±16.03) (p<0.05). The gender distribution in TH (males 58.3%, females 41.7%), GH (males 53.6%, females 46.4%) and PHCCs (males 49.3%, females 50.7%) referred patients was analyzed yielding a statistically significant trend (p<0.036).

Though the sources of PHCCs patients (n=402) referred to the BMHH were numerous, they were categorized mainly as: (i) Ministry of Health (MOH)-PHCCs (n=349, 86.8%), (ii) others (n=53, 13.2%). Overall, physicians working at the MOH-PHCCs mostly referred mental patients to psychiatric institutions for consultation. The sources of GH patients (n=138) referred to BMHH were: (i) general non-teaching hospitals (73.9%), (ii) specialist hospitals (2.9%), (iii) psychiatric hospitals outside the Al-Qaseem region (13%), and finally iv) psychiatric clinics in general and specialist hospitals (10.2%). The comparison of the main referring specialties of TH and GH is shown in Table 1. Further, among the studied total referrals to BMHH, the number of PHC referrals were 402 (74.3%) while in the TH sample, 178 (41.7%) were referred from TH-based Primary Care Clinics (TH-PCCs). The revealed diagnostic pattern of mental disorders in TH, GHs and PHCCs referred patients is shown in Table 2.

| Table 1: Distribution by specialties among GH and TH referrals |
|-----------------|---------|---------|----------|
| **Referring Specialties** | **GH** No. (%) | **TH** No. (%) | **p-value** |
| Medicine | 77 (55.8) | 46 (10.8) | 0.0001 |
| Emergency services | 17 (12.3) | 23 (5.4) | 0.042 |
| Neurology | 3 (22) | 28 (6.6) | 0.1 |
| Dermatology | 2 (1.5) | 5 (1.2) | 0.7 |
| Gastroenterology | 2 (1.5) | 7 (1.6) | 0.7 |
| Psychiatry | 31 (22.5) | 2 (0.5) | 0.0001 |
| Surgery | 3 (2.2) | 19 (3.6) | 0.68 |
| Pediatric | 3 (2.2) | 58 (13.6) | 0.0001 |
| Primary care clinics | - | 178 (41.7) | - |
| Obstetrics and Gynecology | - | 13 (3.2) | - |
| Self-referred | - | 24 (5.7) | - |
| Source of referral not noted | - | 24 (5.7) | - |
| **Total** | **138** | **427** | - |
A Comparison of Psychiatric Referrals

Table 2: Psychiatric diagnoses in TH, GH and PHC referrals

| Diagnosis          | TH  | GH  | PHC | p-value |
|--------------------|-----|-----|-----|---------|
| Dementia           | 20  (4.7) | 13  (9.4) | 20  (5.0) | 0.098  |
| Schizophrenic disorder | 22  (5.1) | 25  (18.1) | 62  (15.4) | 0.0001 |
| Acute psychosis    | 6   (1.4)  | 7   (5.1)  | 8   (2.0)  | 0.036  |
| Mood disorders     | 152 (35.6) | 34  (24.6) | 118 (29.4) | 0.029  |
| Anxiety disorder   | 117 (27.4) | 19  (13.8) | 70  (17.4) | 0.0001 |
| Anxiety depression | -   | 7   (5.1)  | 26  (6.5)  | 0.0001 |
| Somatiform disorder| 7   (1.6)  | 14  (10.2) | 22  (5.2)  | 0.0001 |
| Seizure disorder   | -   | 6   (4.3)  | 18  (4.5)  | 0.0001 |
| Childhood disorders| 58  (13.6) | 1  (0.7)  | 30  (7.5)  | 0.0001 |
| Personality disorders | 21 (4.9)  | -   | -   | 0.0001 |
| Psychosomatic disorders | - | - | 13 (13.2) | - |
| No psychological disorders | 5  (1.2)  | -   | -   | - |
| Diagnoses missing  | -   | 4   (2.9)  | 1   (0.25) | - |
| Miscellaneous      | 19  (4.4)  | 8   (5.9)  | 14  (3.5)  | 0.48 |
| Total              | 427 | 138 | 402 | -       |

DISCUSSION

This study examined the sociodemographic parameters, sources of referrals and diagnostic pattern of psychiatric disorders by assessing the referral letters of patients sent for psychiatric consultation. Unlike TH and PHCCs referral formats, referral forms differed a great deal among GHs, private GHs and clinics. This finding may explain some of the differences including inadequate information found across national and international studies of psychiatric referrals. Hence, there is a need to formulate a uniform psychiatric referral form for use in all THs, GHs, PHCCs and nongovernmental health delivery systems in the KSA. This step in health development would help referring clinicians to be consistent in their documenting data on the referred patients. This would consequently assist researchers in making fair deductions on the information in psychiatric referrals and possibly, improve the overall quality of the referral process. This may also bring clinical advantages including correct diagnosis and appropriate treatment.

According to this study, the age of TH referred patients was comparatively low, a finding which is in agreement with other studies. In addition, most of the patients referred for psychiatric consultation from the three sources were adults, which supports the general view that psychiatric disorders preferentially afflict the young adult population worldwide. Also in agreement with other studies was the finding that fewer male patients were referred from PHCCs while there were fewer females in the TH. This is not in consonance with other research findings. The findings of this study suggest that in this culture, males have free mobility as well as easy access to health care at the tertiary level while females need male chaperones, who are not always available when a visit to the health facility is required. It is therefore much easier for women to go to PHCCs and GHs close to their residences. Moreover, in the PHC settings, records reveal that more women than men present with mental illnesses. Although most types of psychiatric disorders, except drug abuse and antisocial personality disorders, afflict females more
than males,\textsuperscript{4,23,24} the latter tend to manifest severe psychiatric disorders that necessitate referrals to secondary-tertiary care for extensive evaluation, correct diagnosis and suitable treatment. Other socioclinical parameters of referred patients,\textsuperscript{7,15} not considered in this study, may shed additional light on the referral process at the three health delivery systems. For instance, physical comorbidity, one of the important predictors of severity of mental disorders and also a known reason for referral,\textsuperscript{25} was reported in 17% to 38% of referred patients who did require additional intervention by medical specialists.\textsuperscript{5}

As expected, the sources of referrals of psychiatric patients to BMHH were inherently numerous as compared to TH, possibly the result of the study design. Notably, TH-PCCs referrals for psychiatric consultations were half those of PHC referrals to BMHH. The reason for this may be that with the exposure to and management of numerous psychiatric cases the TH-PCC doctors have become more skilled at diagnosing and managing patients without referring them to psychiatric consultants. However, further studies are needed to confirm these tentative findings. According to this study, a significant portion of GH patients were referred mainly from three departments while in the TH referrals came from many more departments and this is in line with the results of earlier studies.\textsuperscript{11,15} This finding could be explained by the fact that unlike in Riyadh, there is only one psychiatric hospital in Al-Qaseem region that provides inpatient services and to which most patients with serious mental disorders and psychiatric emergencies are referred.\textsuperscript{26} Unlike others,\textsuperscript{13} pediatric clinics in the TH referred more patients for psychiatric consultation than the GHs. This could be explained by the accessibility to and availability of child psychiatrists within the TH and also by the pediatric consultants’ ability to detect some child psychiatric disorders. Interestingly, as in TH but unlike GHs, a significant percentage of children (7.5%) were referred from PHCCs to BMHH. This meant that as has been suggested it was necessary to provide appropriate training to PHC physicians on child mental health.\textsuperscript{27} According to this study, the pattern of obstetric and gynecology referrals, 3.2% versus none from GHs and PHCCs, can be attributed to the common belief in Al-Qaseem region that some psychiatric disorders in pregnancy were part of the physiological changes in pregnancy known as “wahm”.\textsuperscript{28} There should be collaboration between obstetric staff and the consultation-liaison psychiatrist at the three health levels to provide better care for pregnant women with mental problems. According to this study, the reasons underlying self-referrals (5.7%) and missing sources of referrals (5.7%), both of which influence psychiatric services,\textsuperscript{29} should be explored.

The pattern of psychiatric disorders among patients referred for psychiatric consultation is reported to vary widely worldwide.\textsuperscript{4,13,15,30} Unlike organic psychotic disorders,\textsuperscript{10,15} acute psychosis and schizophrenia, anxiety-depression and somatoform disorders were the least found among TH patients, a finding consistent with other reports.\textsuperscript{4,15,31} Generally, GH patients with somatic focus are less likely to be referred for psychiatric consultation despite associated significant psychiatric morbidity.\textsuperscript{9} The higher proportion of schizophrenic disorders (15.4%) among patients referred from PHCCs to BMHH is disturbing, because only 5% of the patients attending PHCCs are reported to have psychotic disorders. The implication of this is that PHC physicians should have adequate psychiatric skills to be able to
prescribe psychotropic drugs,\textsuperscript{32} to deal with patients presenting with psychotic disorders and refer them promptly to a psychiatric specialist center. On the other hand, mood, anxiety, and personality disorders were recognized significantly among TH referred patients, which is similar to some\textsuperscript{15} but dissimilar to reports from other studies.\textsuperscript{30} In one study, the authors concluded that although depression was unrecognized in medical patients, it might also be inappropriately suspected and cause the delay of neuromedical evaluation.\textsuperscript{33}

The diagnosis of mixed anxiety-depression,\textsuperscript{18} tentatively referred to as cothymia,\textsuperscript{34} only considered by psychiatric specialists among patients referred from GHs and PHCCs to BMHH, may indicate an increased risk for more severe mood and anxiety disorders.\textsuperscript{35} In contrast, the consultant psychiatrists in THs may be highly skilled in differentiating mixed anxiety-depression disorders into anxiety and mood disorders or this ability to differentiate reflects their expertise. Similarly, the superior skill of the consultant was reflected in diagnosing the most difficult patients with different personality disorders. However, one study reported that psychiatrists are not perfect in terms of high cure rate or making a definite diagnosis initially.\textsuperscript{36} Notably, the diagnosis of seizure disorders formed part of the GH and PHCC referrals instead of neurology clinics where such patients in THs are usually referred. This was because until recently neurology clinics were not available in the GHs of Al-Qassim region. A group of child psychiatric disorders and psychosomatic disorders, commonly diagnosed among patients referred from PHCCs, could be the result of the inability of the PHC physicians to manage child psychiatric and psychosomatic disorders. However, parental acceptance that a child needs psychiatric help determines the referral of the child for psychiatric consultation.\textsuperscript{37} Unlike other studies,\textsuperscript{5,15} this study did not examine the associated medical diseases. It has been suggested that psychiatric consultants at the three health levels should also have adequate medical skills and the appropriate medical training to manage mental patients with comorbid medical diseases.\textsuperscript{5,6}

**CONCLUSIONS AND RECOMMENDATIONS**

The findings of this study are consistent with research mostly undertaken in Western countries. Though there are some differences in referral formats, sources of referral and diagnostic pattern of mental disorders. In the light of these results, the following recommendations are suggested,

1. Health planners should structure and validate a referral letter that could be used uniformly at all three health levels in the KSA,
2. Psychiatrists should have adequate skills in liaison psychiatry to evaluate difficult, referred patients suffering from a variety of psychopathologies,
3. In addition to establishing psychiatric consultation-liaison services at three health settings, there is a definite need to first develop psychiatry in PHC in the KSA, and finally
4. At three settings, researchers should carry out follow-up studies to assessing the impact of psychiatric consultations on the outcome of referred patients.

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