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Research Paper

Psychiatric Comorbidities in Patients Who Are Availing Consultation Liaison Services of a Psychiatry OPD in A Tertiary Care Hospital – A Cross-Sectional Study

Dr. Mano Ranjitha[1]*, Dr. Mohan Reddy[2], Dr. Navya[3], Dr. Veni Nirudya[4]

ABSTRACT

Background: Consultation-Liaison Psychiatry involves both imparting knowledge to nonpsychiatric doctors and interdepartmental teamwork including referrals from Nonpsychiatric departments seeking Psychiatric care for their patients. Hence it is essential to identify Psychiatric illness for referral and prompt management. **Aim:** To study the sociodemographic profile of the patients with comorbid psychiatric conditions referred to the psychiatry department and to identify the pattern of psychiatric illnesses in these patients. **Materials & Methods:** It is a cross-sectional observational study done using MINI [Mini International Neuropsychiatric Interview] as well as structured sociodemographic Performa is used. The Patients referred to Consultation liaison services were screened with the questionnaire to find psychiatric Comorbidities, and ICD 10 criteria were applied as well. **Results:** Most patients referred to the department are males at 62.5% and females at about 37.5%. People who belonged to the geriatric population have had fewer referrals compared with other populations. Most patients referred to consultation liaison services had Psychiatric Comorbidities 79.9%, and about 20.1% had nil Psychiatric Comorbidities. Patients referred from Medicine Department are the Overwhelming majority at 74.4%. Most patients diagnosed with Alcohol Dependence syndrome 21.5% followed by Major Depressive Disorder 9.2%. **Conclusion:** Most patients diagnosed with Alcohol Dependence syndrome 21.5% followed by Major Depressive Disorder 9.2%. Depressive disorder and Suicidality are closely linked. Hence training non-psychiatric doctors, Junior residents, Interns about Psychiatric illnesses is integral for prompt identification, referral of such identified cases to Psychiatry and treatment.

Keywords: *Consultation, disorders, Liaison, Services*

Consultation-liaison (C-L) psychiatry is defined as the region of clinical psychiatry with clinical, teaching and research activities of psychiatrists and allied mental health professionals in the non-psychiatric divisions of a general hospital.[1] According to

[1]Senior Resident, Department of Psychiatry, SDUMC, Kolar
[2]Professor and HOD Department of Psychiatry, SDUMC, Kolar
[3]Associate professor, Department of Psychiatry, Sri Madhusudan Sai Institute of Medical Sciences and Research, Chikkaballapur, Karnataka
[4]Senior Resident, Department of Psychiatry, SDUMC, Kolar
*Corresponding Author

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Mental Health Survey in India done for common Mental disorders, it was found that the older population had a higher prevalence of Depressive disorders, both Lifetime and current, at 6.93% and 3.53% when compared with younger Adults at 4.96% and 2.54% respectively. [2] Mental disorders in many individuals are affected by physical conditions. However, a huge number of patients suffering from medical conditions also experience mental health problems. Psychiatric comorbidity is associated with an increased hospital stay, high medical costs and recurrent hospitalization.[3] Consultation-Liaison Psychiatry (CLP) is a speciality of psychiatry which provides assessment and action for hospital patients with mental health co-occurring conditions. It also includes teaching and research activities on mental health comorbidity to the medical staff of other non-psychiatric departments of general hospitals.[4] Though it does not impact reduction of length of hospital stay, it positively impacts mental health problems.[5] Medical and psychiatric professionals can bring together projects to ensure the best way to minimize the existing gap between medical specialities and psychiatry. [6]

In rural areas, the awareness and knowledge about mental illnesses are almost non-existent. In contrast, people living in urban settings are much more aware of their conditions like anxiety, depression etc. and the technology to get an amount of knowledge in the snap of their fingers.[7] This has drawn people in urban settings to seek psychiatric help when needed. Rural people have little to no knowledge about their psychiatric conditions, and a lot of false information, fear-mongering, and stigmatization of mental illnesses affect the quality of mental health. Hence studies are needed to evaluate patients referred from other departments and to know the pattern of psychiatric diseases prevalent among them. It is essential to psycho-educate them about their condition, socioeconomic, interpersonal issues etc., if any. This kind of therapy forms an inherent part of psychiatry itself. Psychological stressors like interpersonal relationship problems, sociocultural issues, and financial issues play a huge role in these patients' psychiatric morbidity.[8] Diagnosing and treating the underlying psychiatric comorbidities helps speed the recovery of their physical illnesses. The clinician needs to identify common psychiatric conditions like depression and anxiety so that they can be referred to psychiatry OPD as and when required. [9]

By considering all the above circumstances, the present study aims to examine the sociodemographic portrait of the participants with comorbid psychiatric conditions referred to the psychiatry department and to identify the pattern of psychiatric illnesses in these patients.

MATERIALS & METHODS

This was a cross-sectional observational study performed in the Department of Psychiatry in RL Jalappa Hospital and Research Centre from January 2021 to March 2022. After obtaining ethical clearance from the Institutional Ethical Committee (IEC), informed consent was given to the patients. The patients aged 18-65 years who are referred from other departments to psychiatry OPD for Consultation Liaison services were included in the study. The patients of the age group below 18 years having a psychiatric illness or on treatment and patients with delirium and complex withdrawal seizures, speech or hearing impairment and are not willing to participate were excluded from the study. A total of 293 patients were included in the present study. The Sociodemographic details of all the patients were recorded.

All the patients will be diagnosed using a Mini International Neuropsychiatric interview (MINI). By applying the MINI scale, the underlying psychiatric disorders which were not previously thought of were brought to light, and patients received appropriate treatment.

Statistical Analysis

All the collected data were entered in Microsoft Excel, and the SPSS 22 version software was used to perform the analysis. Frequencies and percentages were used to depict the categorical data. For qualitative data, the Chi-square test or Fischer's exact test was used. A statistical test for significance was performed using an independent t-test to determine the average difference between two numerical variables.

RESULTS

A total of 293 People were taken for the study according to the inclusion criteria. Most of the Patients referred for the consultation belonged between 21 to 30 years old at 30.7% followed by 31 to 40 years old at 26.3%. It was found that subjects who belonged to the geriatric population have had less referrals than other population. P value (Probability that the result is accurate) of <0.05 was considered statistically significant after assuming all the rules of statistical tests.

Table 1: Distribution of subjects according to age group

Age group	Frequency	Percent
<20yrs	19	6.5
21-30yrs	90	30.7
31-40yrs	77	26.3
41-50yrs	52	17.7
51-60yrs	34	11.6
61-70yrs	21	7.2
Total	293	100.0

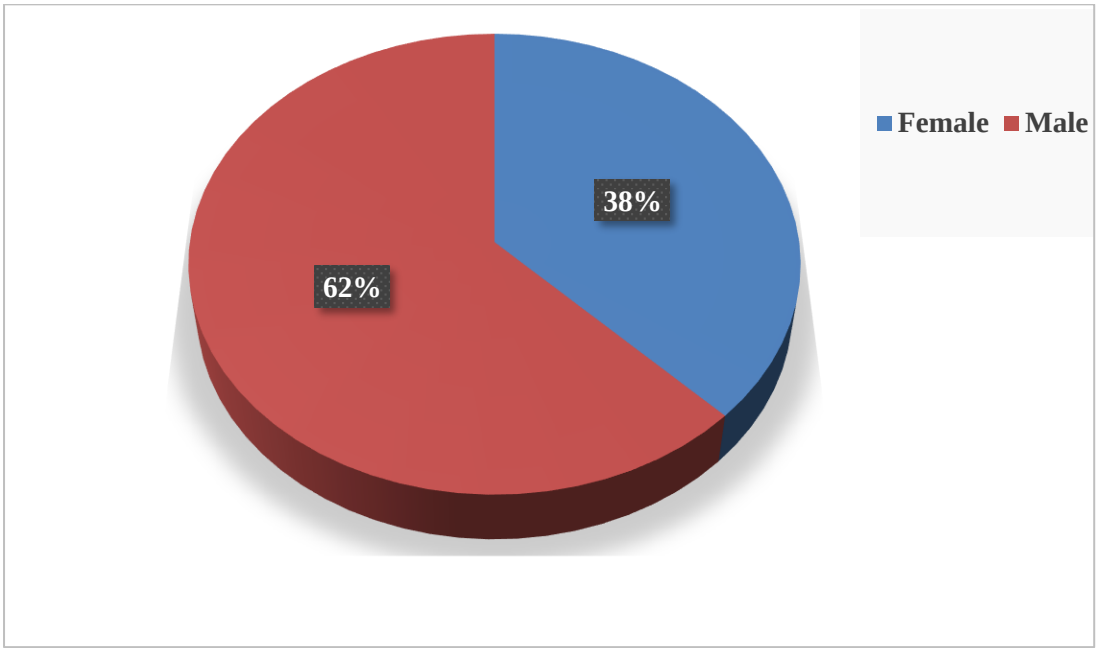

Figure 1: Graph showing Distribution of subjects according to sex

Table 2: Distribution of subjects according to occupation

Occupation	Frequency	Percent
Unemployed	111	37.9
Home maker	7	2.4
Professional	1	.3
Semi Professional	4	1.4
Skilled Worker	16	5.5
Unskilled Worker	154	52.6
Total	293	100.0

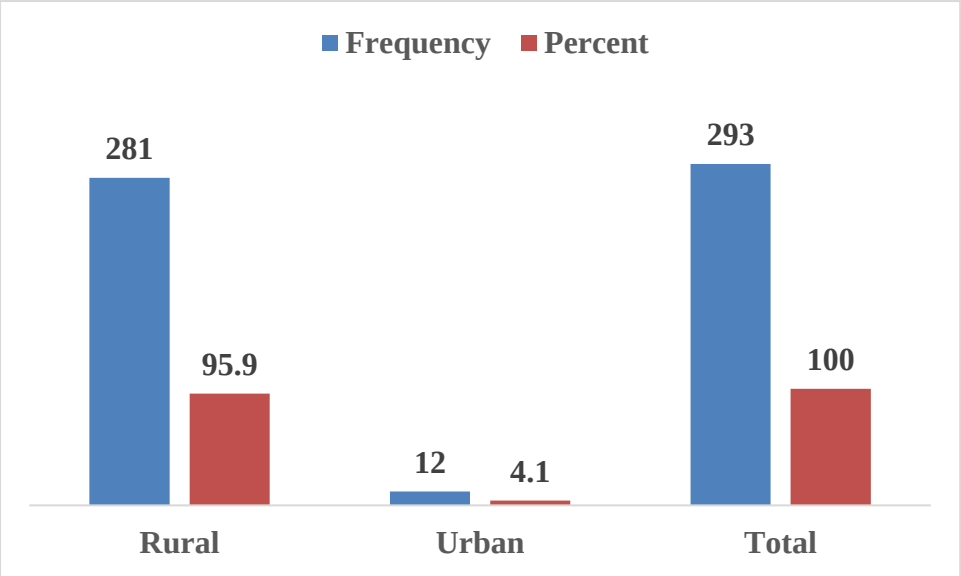

Figure 3: Distribution of subjects according to locality

Table 3: Distribution of subjects according to Psychiatric comorbidities

Psychiatric comorbidities	Frequency	Percent
No	59	20.1
Yes	234	79.9
Total	293	100.0

Table 4: Distribution of subjects according to referral

	Frequency	Percent
Cardiology	1	0.3
EMD	13	4.4
ENT	9	3.1
Medicine	218	74.4
OBG	6	2.0
Ophthalmology	2	.7
Orthopaedic	9	3.1
Surgery	35	11.9
Total	293	100.0

Table 5: Distribution of subjects according to reason for referral

	Frequency	**Percent**
Agitation/altered behaviour	28	9.6
Anxiety	7	2.4
Deaddiction	71	24.1
Low mood	23	7.8
Psychiatric illness	9	3.1
Sleep disturbances	36	12.3
Somatization	5	1.7
Suicide attempt	96	32.8
Others	18	6.2
Total	293	100.0

Table 6: Frequency Distribution of comorbidities

	Frequency	**Percent**
Haematological	4	1.365188
Respiratory	9	3.071672
Infections	4	1.365188
Endocrine	49	16.72355
CNS	14	4.778157
Metabolic	3	1.023891
CVS	4	1.365188
Gastrointestinal	18	6.143345
Genitourinary	7	2.389078
OBG	2	0.682594
Others	34	11.6041
No Comorbidities	179	61.09215

Table 7: Distribution of subjects according to Mini Scale

	Frequency	**Percent**
ADS	66	22.5
ADS, MOD SUI, MDD-CURR	1	.3
ADS, ASPD	1	.3
ADS, MDD	1	.3
ADS, SUI-MILD	1	.3
ADS, SUI-MOD	2	.7
AL ABU	9	3.1
AL ABU, ASPD	1	.3
CAN DEP, ADS, PSY-CURR	1	.3
CAN DS	2	.7
GAD	1	.3
MANIA -PAST	1	.3
MANIA-CURR	1	.3
MDD	1	.3
MDD-CURR	18	6.1

	Frequency	Percent
MDD-CURR, SUI-HIGH	1	.3
MDD-CURR, SUI-MOD	1	.3
MISC	2	.7
MOD SUI, ADS	1	.3
MOD SUI, ASPD	1	.3
MOOD PSY	1	.3
MOOD PSY CURR	1	.3
MOOD WOT PSY-CURR	1	.3
OPIOD ABUSE	1	.3
PANIC DIS	7	2.4
PSY-CURR	4	1.4
PSY-LIFE	10	3.4
PSY-LIFE, AL ABU	1	.3
PTSD	1	.3
RDD-CURR	3	1.0
SOCI PHOB	3	1.0
SUI-HIGH	10	3.4
SUI-HIGH, MDD-CURR	3	1.0
SUI-LOW	18	6.1
SUI-LOW, AL ABU	1	.3
SUI-MILD	8	2.7
SUI-MILD, ADS, ASPD	1	.3
SUI-MOD	29	9.9
SUI-MOD, MDD-CURR	1	.3
SUI-MOD, ADS	2	.7
SUI-MOD, AL ABU	2	.7
SUI-MOD, MDD	1	.3
SUI-MOD, MDD-CURR	1	.3
No psychiatric disorder	70	23.9
Total	293	100.0

Table 8: Frequency Distribution of ICD 10

	Frequency	Percent
Substance Use disorders	101	34.47099
Intentional Self harm	88	30.03413
Mood Disorders	39	13.31058
Neurotic and stress related Disorders	61	20.81911
Personality Disorder	4	1.365188
Schizophrenia	16	5.460751
sleep disorders	5	1.706485
Others	3	1.023891
No Psychiatry	24	8.191126

Table 9: Comparison of mean age according to Psychiatric comorbidities.

Psychiatric comorbidities	Mean age	Std. Deviation	P value
Absent	35.12	14.877	0.082
Present	38.42	12.507	

Table 10: Distribution of subjects according to Psychiatric comorbidities and sex

	Absent		Present	
	N	%	N	%
FEMALE	44	40.0%	66	60.0%
MALE	15	8.2%	168	91.8%

P Value 0.001, there was a statistically significant difference found between Psychiatric comorbidities and sex

Table 11: Distribution of subjects according to Psychiatric comorbidities and occupation

	Absent		Present	
	N	%	N	%
Unemployed	40	36.0%	71	64.0%
Home maker	0	.0%	7	100.0%
Professional	1	100.0%	0	.0%
Semi Professional	1	25.0%	3	75.0%
Skilled Worker	1	6.3%	15	93.8%
Unskilled Worker	16	10.4%	138	89.6%

P Value <0.001, there was statistically significant difference found between Psychiatric comorbidities and occupation.

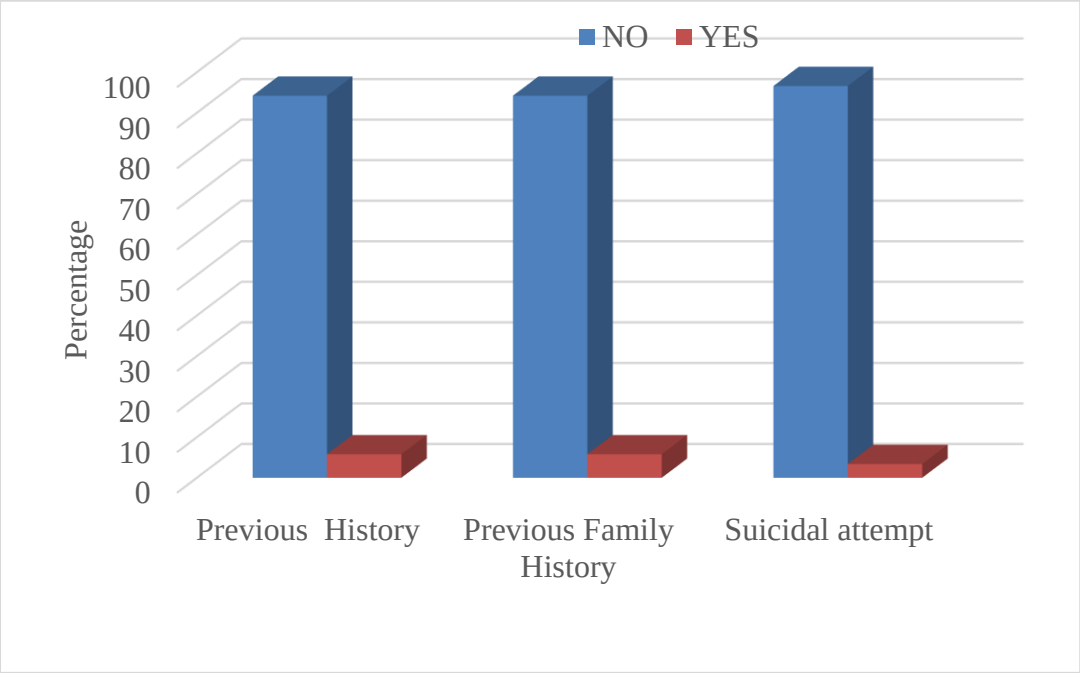

Figure 4: Graph showing Distribution of subjects according to Psychiatric comorbidities and other comorbidities

DISCUSSION

Consultation Liaison Psychiatry deals with Treating other medical or surgical comorbidities in a patient with Psychiatric illness or vice versa. The psychiatry unit of a general hospital is not adequate without C-L services. According to biopsychosocial theory, every disorder has a psychological and social component. As a result, its importance is seen in the context of a holistic approach to care that considers both the factors of the psychological and physical aspects of any condition. [10] This collaborative environment only possible to minimize hospital stays but also better patient quality and essence of life and lessen the economic burden of medical conditions.

As per the study results, the percentage of males account for 62.5% more than females which is similar to the study of Santosh Ramdurg who stated that males are most referred people in hospital compared to females in psychiatry. [11-12]

The age of the patients in the present study belonged to 21-30 years, which represents 30% of population included in the study which is coordination with other survey reports.[13] Whereas there are two other contrasting reports to the present study where most of the study subjects belonged to 31-45 years of age, and few pieces concluded middle age as concluded by Patra B and his co-investigators. [14-16]

In the present study, most of the subject's occupation was noted as unskilled workers, whereas, in another study, it is Homemaker. [17] Varchasvi Mudgal et al. in their study reported that most of the people referred are unemployed. [18]

In our study, most people are from rural backgrounds representing 95.9% (n=281) which is predominant compared to the urban population of 4.1%(n=12). These reports are contrary to another study reports where urban population tops over rural Population.[18] It is also noted in the present study that, patients belonging to the above Poverty Line are the Majority at 64.2% compared to the below poverty line at 35.8%.

In the present study, it is also noted that the main origin of referral is from the department of Medicine, an overwhelming majority compared to other sources of referrals which is comparable to another study as well. [19-20]

In a study by Paetra, the main issue for referral to consultation Liaison Psychiatry included altered sensorium behavioral abnormalities (21.65%), followed by alcohol-related cases (18.47%). [21] Whereas in another study, the most common contributory concern for this referral is baffling somatic symptoms. [22], which is contrary to our Study. In another study done in Europe, the most common rationale and grounds for referral is suicide attempts 31% which is concordance with our Study. [23]

In another conducted Study, the most common rationale for the purpose for the referral was that psychiatric clearance was defined from the perspective of kidney donor and bone marrow transplant (BMT). The total number of stem cell transplant recipients was 23.1%. This was mainly followed by the overall assessment of current suicidal ideation and suicidal behavior 16.9%. [24-25]

The present study focused mainly on noting the most common Psychiatric diagnosis is Nil Psychiatric illness 23.9% according to the Screening by MINI scale. Whereas, after

Applying the ICD 10 criteria, most patients diagnosed have substance use disorders at 34.4%, followed by Intentional self-harm at 30%. Neurotic and stress-related disorders are the third most common diagnosis at 20.8%. Whereas in the other Study, Neurotic and stress-related disorders 41.7% are the Majority, followed by substance use disorders 12.7% which cannot be considered within concordance to the findings of our study.[26]

In another study conducted for similar subjects, the focus was on overall Alcohol dependence syndrome (ADS) and intentional self-harm. Both of these findings contributed to overall percentage of (21% each). This was also noted commonly for the two psychiatric disorders defined under the sub-category of C-L psychiatry. These results were found to be most resonating with our study. [23]

In another study, Depression seems to be the most commonly diagnosed Psychiatric condition at 24.4%; this was secondary to drug use disorder at 19.7%. As one of the most common diagnoses, substance use disorder concordant with our Study. [12]

This study states endocrine problems are the most common nonpsychiatric diagnosis, accounting for 49% of the referred population. This represents almost half of the total population. The second most frequent label is "others," which accounts for 34% of cases. Other studies have found that poisoning, injury, or burns are the most common physical diagnoses (at 36.6%), followed by central nervous system abnormalities (10.5%).[18]

In our study, there seems to be a statistically significant difference found between Psychiatric Comorbidities and Sex at a P value of 0.001. there was a statistically significant difference between Psychiatric comorbidities and occupation at P Value <0.001, and there was no statistically significant difference between Psychiatric comorbidities and marital status at a P-Value of 0.868.

CONCLUSION

Major Depressive disorder and Suicidality are closely linked. Warning signs of Suicide need to be identified on time, and measures need to be taken to prevent the same from occurring on the premises of the Hospital and in the future. Hence training of nonpsychiatric doctors, Junior residents, and Interns about Psychiatric illnesses is integral for prompt identification, referral of such identified cases to Psychiatry and commencing the treatment. If needed, Patients who have Psychiatric emergencies need to be shifted to Psychiatric wards for Monitoring and therapy.

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Conflict of Interest
The author(s) declared no conflict of interest.

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