Original Research Article

A Study on Patterns of Psychiatric Referrals from other Specialties at a Tertiary Care Center in Goa

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ABSTRACT

Background: The increasing recognition of psychiatric disorders in general medical settings underscores the need for timely psychiatric referrals to ensure comprehensive patient care. In tertiary care hospitals, integrating mental health services with other specialties is critical for addressing psychiatric comorbidities that complicate physical illnesses, prolong hospital stays, and elevate healthcare costs.
Methodology: This cross-sectional study was conducted at Goa Medical College, a tertiary care centre over one month. A total of 100 patients referred from various departments were enrolled via convenience sampling. Data were collected using a semi-structured socio-demographic proforma and analysed with SPSS. Diagnoses were made per ICD-10 criteria, and referral patterns were examined by age, gender, department, reasons, and diagnostic categories.
Results: Among 100 participants with complete age data, the mean age was 44.0 ± 16.4 years. The highest frequency of referrals was observed in the 31-40 years age group (30%), with males constituting 76% of referrals. The Surgery department (33%), followed by Medicine (25%) and TBCD (16%), were the major sources of referrals. Predominant referral reasons included alcohol use (35%), altered sensorium (25%), and suicidal attempts (11%). The most common psychiatric diagnoses were alcohol use disorder (43%) and organic mental disorder (16%), with additional cases of deliberate self-harm (12%), psychotic (10%), and neurotic disorders (10%).
Conclusion: Targeted interventions among middle-aged males and key departments may enhance early detection and treatment. Strengthening consultation-liaison psychiatry can improve outcomes, reduce hospital stays, and lower costs. Overall, this study provides essential regional insights.

Keywords: Psychiatric Referrals, Tertiary Care, Consultation-Liaison Psychiatry, Integrated Mental Health.

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INTRODUCTION

The recognition of psychiatric disorders in general medical settings has increased significantly in recent decades. This shows the growing awareness of mental health issues in medically ill patients and the acknowledgment of their impact on overall health outcomes. In tertiary care hospitals, psychiatric referrals from other specialties are essential for ensuring holistic patient care. Mental health conditions coexist with physical illnesses, the failure to recognize and treat them can lead to poor prognosis and increased healthcare costs [1]. Thus, combining mental health services within tertiary care hospitals is necessary for medical care. Psychiatric disorders are prevalent in general medicine with studies indicating that 20 to 46 percent of hospitalized patients have at least one diagnosable psychiatric condition [2]. The burden of undiagnosed psychiatric disorders can be significant. This leads to extended hospital stays, higher costs, and increased morbidity. A study conducted in North India, where 24% were alcohol dependence and 20.41% were mood disorders among the most common psychiatric diagnoses in referred patients [3].

Delirium is commonly observed in elderly patients, especially those recovering from surgeries or chronic illnesses. It is related to medical conditions and the use of specific medications. Research in India identified delirium as a prevalent reason for psychiatric referrals in tertiary care hospitals [4]. The prevalence of substance use disorders in medical settings is significant. In North India, substance use accounted for 26.2 percent of psychiatric referrals, with alcohol dependence being the most common diagnosis [3]. Many patients present with somatic complaints such as chronic pain and fatigue that may have underlying psychiatric origins. Addressing these issues through psychiatric referrals can improve patient outcomes [1].
Consultation-liaison psychiatry services have shown effectiveness in decreasing hospital stays, reducing unplanned readmissions, and improving overall patient care [5-6]. However, several challenges affect effective psychiatric referrals such as inadequate training among non-psychiatric clinicians, time constraints, and the stigma related to mental illness [7]. Timely psychiatric referrals lead to better treatment adherence and prognosis. Early intervention by psychiatric services improves the quality of life for patients with medical and psychiatric comorbidities.
Despite the growing recognition of psychiatric disorders in general medical settings, research regarding psychiatric referrals remains limited mainly in India. However, access and utilization remain suboptimal because of the stigma and limited awareness among non-psychiatric clinicians [8].
Studies focused on global patterns with relatively few examining region-specific data. Previous research has highlighted psychiatric referral patterns in North India and other international settings [9-10], but there is a lack of data on Goa. Furthermore, existing studies often fail to assess clinician awareness and patient characteristics that influence referral patterns. Therefore, updated research is necessary to address these gaps and improve psychiatric service integration in tertiary care hospitals. The primary objective of this study is to analyze the patterns of psychiatric referrals from other specialties in a tertiary care hospital in Goa.

METHODOLOGY

This cross-sectional study was conducted at Goa Medical College, a tertiary care center. The study focused on evaluating the patterns of psychiatric referrals from various medical and surgical departments. The study was carried out over a one-month period from 01/7/2024 to 31/7/2025. Before initiation, the study received approval from the Institutional Ethical Committee.
A convenient sampling method was used to recruit participants. A total of 100 patients who met the inclusion criteria were enrolled.

Inclusion and Exclusion Criteria

Patients admitted in different departments of Goa Medical College for whom psychiatric consultation was asked during the study period were included in this study. Patients referred solely for disability assessment were excluded.

Data Collection

Data were collected using a semi-structured socio-demographic proforma. Detailed information on the sociodemographic characteristics, psychiatric history, and mental status examination of each patient was obtained from interview, referral forms and case records. Psychiatric diagnoses were established according to the criteria set forth in the International Classification of Diseases, 10th Edition (ICD-10). Additionally, the primary medical or surgical diagnoses were recorded, along with the specific department of admission and the stated reasons for the psychiatric consultation.

Table 1: Psychiatric Diagnoses Among Participants

Psychiatric Diagnoses	Frequency %
Alcohol use disorder	43
Organic mental disorder	16
Deliberate self-harm	12
Psychotic disorder	10
Mood disorder	0
Neurotic disorder	10
Non organic insomnia	3
No psychiatric diagnosis	2
Under evaluation	4

Data Analysis

The data collected were systematically entered and analyzed using the latest version of SPSS software. Both descriptive statistics and inferential statistical tests were used to evaluate the data. Statistical significance was determined using a p-value threshold of <0.05, with appropriate tests selected based on the nature and distribution of the variables.

RESULTS

Table 1: Age Distribution of Participants

Age Group (years)	Frequency (%)
0–10	1 (1.0%)
11–20	7 (7.0%)
21–30	8 (8.0%)
31–40	29 (29.9%)
41–50	21 (21.0%)
51–60	13 (13.0%)
61–70	12 (12.0%)
71–80	5 (5.0%)
>80	1 (1.0%)

A total of 100 participants with available age data were included in the analysis. The mean age of the participants was 44.0 ± 16.4 years. Notably, the largest proportion of referrals was observed in the 31–40 years age group (30%), followed by the 41–50 years (22%) and 51–60 years (13%) age groups. The extreme age ranges (<10 and >80 years) each accounted for only 1.0% of the referrals.

Table 2: Gender Distribution of Participants

Gender	Frequency (%)
Male	76 (76%)
Female	24 (24%)
Total	**100 (100%)**

The gender distribution revealed that 76% were male while 24% were female.

Table 3: Department Distribution of Psychiatric Referrals

Department	%
Surgery	33
Medicine	25
TBCD	16
Orthopaedic	3
Pediatrics	3
Dermatology	3
Plastic surgery	3
Neurosurgery	3
OBG	2
Nephrology	2
Covid rehab	2
ENT	1
Oncology	1
Urology	1
Neurology	1
OFMS	1

The analysis of departmental referrals indicated that the highest number of psychiatric consultations originated from the Surgery department (33%), followed by Medicine (25%) and TBCD (16%). A smaller proportion of referrals came from other departments such as Orthopedics, Pediatrics, Dermatology, Plastic Surgery, Neurosurgery, OBG, Nephrology, Covid Rehab, ENT, Oncology, Urology, Neurology, and OFMS. The analysis of reasons for referral revealed that the most common reason was alcohol use (35%), followed by altered sensorium (25%) and suicidal attempts (12%). Other reasons included aggression and irritability (8%), previous psychiatric disorder (6%), insomnia (4%), depressive features (4%), anxiety (3%), multiple somatic complaints (2%), and no psychiatric diagnosis (1%).

Table 4: Reasons for Psychiatric Referral

Reason for referral	Frequency %
Alcohol use	35
Altered sensorium	25
Suicidal attempt	12
Aggression & irritability	9
Previous psychiatric disorder	6
Insomnia	4
Depressive features	4
Anxiety	3
Multiple somatic complaints	2

The diagnostic profile of the psychiatric referrals revealed that alcohol use disorder was the predominant diagnosis, observed in 43% of the cases, followed by organic mental disorder (16%). Deliberate self-harm was noted in 12% of the participants, while both psychotic and neurotic disorders were identified in 10% each. Non-organic insomnia, , cases with no psychiatric diagnosis and under evaluation were observed in 3%, 2%, and 4% of the referrals, respectively.

DISCUSSION

This study found that the highest proportion of psychiatric referrals occurred in the 31 to 40 years age group that has 30%. This was like the studies by Goyal et al which suggest that middle-aged individuals face significant life stressors such as career pressures, financial responsibilities, and family obligations which contributes to increased mental health concerns [9]. This highlights the vulnerability of middle-aged adults to mental health issues. While middle-aged adults constituted the largest referral group, other age demographics also showed notable patterns. The 41 to 50 years group accounts for 22% of referrals, further supporting that psychiatric issues continue beyond early adulthood. Conversely, younger adults (21to 30 years) represented only 9%, despite existing literature suggesting high psychiatric morbidity in this demographic by study done by Tema and others [11]. Older adults (>60 years) comprised a smaller proportion of referrals possibly due to under-detection of psychiatric symptoms, misattribution to aging, or reduced healthcare-seeking behavior [12]. Similarly, the minimal referrals from children (<10 years, 1.0%) may reflect lower prevalence or a lack of psychiatric consultation in pediatric cases.

This study revealed a significant gender disparity, with 76% of psychiatric referrals being male. This is consistent with Mudgal et al and Paudel et al where male referrals ranged from 52.5% to 56.4% [13]. The predominance of male referrals may be due to high rates of substance use disorders, externalizing behaviors, and increased engagement in risk-taking behaviors that lead to psychiatric crises requiring hospitalization [14]. Despite lower referral rates, psychiatric disorders among women may be under-recognized or under-reported due to gender differences in symptomatology and help-seeking behavior. Women are more likely to experience internalizing disorders such as depression and anxiety, which may not always lead to urgent psychiatric consultations [14]. Additionally, societal stigma may discourage women from seeking psychiatric help, while healthcare professionals might under-diagnose their symptoms compared to men [15]. The highest number of psychiatric consultations in our study originated from the Surgery (33%), Medicine (25%), and TBCD (16%) departments. This was observed to be similar to findings from Keertish and others, where 59% of referrals were from the Medicine department, followed by Surgery and Pulmonology [16]. Medically unexplained somatic symptoms, post-operative delirium, and chronic illnesses requiring long-term care may contribute to increased psychiatric referrals from these departments. The low referral rates from departments such as OBG, Neurology, and Oncology suggest a potential under-recognition of psychiatric conditions in these specialties. Improved psychiatric training for non-psychiatric clinicians can improve early identification and management of psychiatric disorders in various medical settings. Routine psychiatric screening should be included in hospital protocols to ensure timely intervention for at-risk patients. Alcohol use was the most common reason for referral (35%), followed by altered sensorium (25%) and suicidal attempts (12%) in our study. These findings are like studies done by alaja et al, where substance use disorders accounted for 28% of psychiatric referrals, predominantly among middle-aged men [17]. Suicidal attempts, constituting 11% of referrals, highlight the need for robust suicide prevention strategies in hospital settings. Previous research found that up to 24.4% of psychiatric referrals were related to suicide attempts, underscoring the importance of crisis intervention and mental health support services.

Alcohol use disorder was the most prevalent psychiatric diagnosis with 43%, which is like studies which emphasized the significant burden of substance use disorders among hospitalized patients. This highlights the need for integrated addiction treatment within general hospital psychiatry units. Organic mental disorders like delirium and dementia accounted for 16 % of diagnoses in our study. These findings support prior research indicating that cognitive disturbances in hospitalized patients often necessitate psychiatric evaluation. Given the aging population and increased life expectancy, psychiatric services must be equipped to address neuropsychiatric complications in medically ill patients. Deliberate self-harm (11%) was another significant diagnosis in this study, that reinforces the need for comprehensive suicide prevention frameworks. Additionally, psychotic disorders (10%) and neurotic disorders (10%) were frequently diagnosed, consistent with study by Mudgal et al. suggesting that schizophrenia, bipolar disorder, and anxiety disorders often emerge in early adulthood and require hospitalization.

CONCLUSION

This study provides crucial information into the patterns of psychiatric referrals at a tertiary care center in Goa, highlighting key demographic and clinical trends. Our findings demonstrate that the majority of referrals were from middle-aged adults, particularly within the 31 to 40 years age group, and predominantly male. Departments such as Surgery, Medicine, and TBCD accounted for the highest referral rates, underscoring the need for integrated psychiatric evaluation within these specialties. The predominant reasons for referral namely, alcohol use, altered sensorium, and suicidal attempts correlating with a high incidence of alcohol use disorder and organic mental disorders among the referred patients. These findings emphasize the critical role of consultation-liaison psychiatry in reducing hospital stays, lowering healthcare costs, and enhancing overall treatment outcomes. Furthermore, the study identifies gaps in referral practices, particularly in under-recognized departments, and stresses the need for enhanced training among non-psychiatric clinicians. Overall, our research advocates for targeted, gender-sensitive interventions and the seamless integration of mental health services into general medical care, thereby promoting holistic patient care and improved clinical outcomes.

Limitations of the Study

The single-center design may restrict the generalizability of the findings. Patient demographics, referral practices, and the prevalence of psychiatric disorders can vary widely across different healthcare settings. Future studies that include multiple centers would help to validate these findings and provide a broader perspective. The cross-sectional nature of the study limits our ability to establish causality or assess the long-term outcomes of patients following psychiatric referral. Longitudinal studies are necessary to determine whether early psychiatric interventions in these settings lead to improved clinical outcomes, reduced readmission rates, or enhanced overall quality of care.

Another limitation is the potential for referral bias. The decision to refer a patient for psychiatric evaluation is often based on the subjective judgment of the referring clinician, which can vary between departments and individual practitioners. Such variability may lead to an underrepresentation or overrepresentation of certain conditions, thereby affecting the overall diagnostic profile. Standardizing referral criteria and incorporating objective screening tools in future studies may help mitigate this bias.

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