AN ANALYSIS OF REFERRALS RECEIVED BY A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL

by

MARLENE DOR

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SUPERVISOR: DR VJ EHLERS

JOINT SUPERVISOR: MRS MM VAN DER MERWE

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Student number: 552-438-5

DECLARATION

I declare that *AN ANALYSIS OF REFERRALS RECEIVED BY A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

....

M DOR **DATE**

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STUDENT:	**M DOR**
DEGREE:	**MASTER OF ARTS IN NURSING SCIENCE**
DEPARTMENT:	**ADVANCED NURSING SCIENCES, UNIVERSITY OF SOUTH AFRICA**
SUPERVISOR:	**DR VJ EHLERS**
JOINT SUPERVISOR:	**MRS MM VAN DER MERWE**

Abstract

The study sought to analyse the referrals received by a psychiatric unit in a general hospital in the Western Cape by studying the referral letters and the referral responses. The study sought to determine which departments were referring patients and which patients were being referred. The completeness and appropriateness of the referrals were also studied.

The major inferences drawn from this study are that health care workers have a poor concept of what information the psychiatric units needs and about the scope and function of the unit. The poor feedback from the psychiatric unit to the referral source is indicative of the poor communication amongst the health care team members.

KEY CONCEPTS

Psychiatric referrals, psychiatric unit, referral source.

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List of abbreviations

AIDS	=	Acquired Immune-Deficiency Syndrome
ANC	=	African National Council
DSM4R	=	Diagnostic and Statistical Manual 4 Revised
OPD	=	Outpatient Department
PHC	=	Primary Health Care
PTSD	=	Post-traumatic Stress Disorder
RSA	=	Republic of South Africa
SANC	=	South African Nursing Council
UK	=	United Kingdom
USA	=	United States of America

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CHAPTER 1

Background information

1.1 INTRODUCTION

The trend in medicine in developed countries is to treat patients holistically which includes the psychological dimension. It is also noted that many more psychiatric patients are being treated in general hospitals (Ashley-Smith 1991:1). It was thought that by establishing psychiatric units in general hospitals, the need to treat all patients holistically would be met. This research investigated the utilisation of a psychiatric unit in a general hospital in the Western Cape by studying the referrals received by the psychiatric unit from the other departments in the hospital or services in the community.

1.2 BACKGROUND TO THIS RESEARCH

When working in a general hospital without a psychiatric unit, it became apparent that there was a gap in health care that a lack of appropriate psychiatric care facilities left. This was

substantiated by the literature review of research done by Ashley-Smith (1991), Gagiano (1992a), Gous (1992), Granville (1993), Hart (1992), Savoca (1999), 33rd Subcommittee Mental Health Matters (1993) and Uys and Middleton (1997).

Ashley-Smith (1991:2) stated that in the Republic of South Africa (RSA), previous involvement of psychiatrists had been in the form of part-time outpatient department sessions only; all patients needing psychiatric care were referred to distant psychiatric hospitals at great inconvenience and cost. This might have had an effect on the referral habits of practitioners.

Gagiano (1992a:311) recorded that for many years psychiatric services in the RSA had been rendered mainly at a tertiary level. This was very expensive and ineffective as indicated by the high relapse rates, lack of early detection of psychiatric illnesses and the absence of primary intervention programmes. Treatment programmes were less effective because patients were removed from their social and family systems and treated in isolation. The expense and the "less effective" treatment programme might have affected the number of referrals to psychiatric services.

Gous (1992:316) noted that the need for training physicians orientated toward primary care was emphasised as a solution to the problems experienced by primary care physicians in the RSA who might feel ill equipped to handle psychiatric problems in their practices. Lack of the necessary psychiatric knowledge could affect the referral habits of physicians in primary health care settings.

According to Granville (1993:96), the management of common losses, amputations, dying, bereavement, rejection and Auto Immune Deficiency Syndrome (AIDS) was handled inadequately in general medical settings in the United Kingdom (UK). Thus referrals for "nonpsychiatric" conditions or referrals for prevention interventions, were not included in the standardised routine and thus was also not taught to students.

Hart (1992:331) urged that the historical problems of psychiatric services, being separated

from general medical services in the RSA, needed to be addressed. The stigma of going to a specialised psychiatric hospital might have influenced the number of referrals to psychiatric units. Referrals and compliance might increase with decreased stigmatisation of having a psychiatric illness and being seen at a psychiatric unit.

According to Savoca (1999:457), in the United States of America (USA), hospital use in the general medical sector was significantly higher for people with co-existing physical and psychiatric conditions. Both conditions needed to be attended to, which could be achieved through appropriate referrals to psychiatric units.

The 33rd Subcommittee Mental Health Matters (1993:9) observed that there was a need for consultative psychiatric services at secondary level in the RSA which were not in existence at that time (1993). Thus because there were no services, the referral rates were almost non-existent.

The first psychiatric outpatient services in the RSA were established in 1957 (Uys & Middleton 1997:10). Outpatient departments were developed at all the large psychiatric hospitals in the 1970s and inpatient numbers began to decrease, but psychiatry was still separate from general medicine.

Since the implementation of Regulation R425 of 1985, more in-depth theoretical and practical graining was given to nursing students in the RSA (Regulation R425, 1985, paragraph 1(9)). This implied that more nurses would be competent to handle psychiatric issues, and thus the need to refer patients to psychiatric units might decrease.

1.3 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

A study done in the Gauteng Province in the RSA revealed that patients in a general hospital, admitted for medical or surgical conditions were perceived as their medical or surgical conditions only, and cognisance was not given to their psychological dimensions. The standard history sheets, used for taking the patients' details and histories, allocated no spaces

for the patients' psychiatric histories (Swartz 1992:371). Also in the RSA, it was also noted that there were no formal expert counselling given pre- or postamputations to prevent or detect early signs of psychiatric conditions such as major depression. Neither was there expert formal counselling given to patients before or after the diagnosis of cancer, necessary to counteract potential psychiatric conditions including reactive psychosis and major depression (Dobson 1990:159). This research will investigate the referrals received by a psychiatric unit in a general hospital to determine the extent of the problem in a general hospital in the Western Province.

Co-morbidity (where two or more illnesses occur in a patient simultaneously) was not always considered by staff, and thus staff did not tend to ensure that holistic care was given (Granville 1993:103). McCloskey (1990:81) concurred with this when saying that specialisation by practitioners was one of the main causes of discontinuity of patient care across hospital and community boundaries. Emotional disorders might not only predispose patients toward poor physical health through biological processes, but they might also compound the diagnoses of medical diseases as well as delay recuperation (Savoca 1999:457). Thus patients should be viewed holistically to succeed in treating them holistically. The holistic approach to patient care could be related to families of patients with Alzheimers' disease who require psychological support and genetic counselling to enable them to function optimally (Pearl 1997:720). According to Savoca's (1999:459), USA research findings, larger numbers of patients with chronic medical illnesses also had psychiatric illnesses than those who did not have accompanying psychiatric illnesses, namely 53,0 percent versus 40,0 percent. This emphasised the need for holistic care to assist health care consumers to attain and maintain optimal levels of health. This study will investigate the referral rate to a psychiatric unit in a general hospital to examine the extent to which psychiatry is utilised in the endeavour to treat patients holistically.

The African National Council (ANC) stated in their National Health Plan that there was a poor multidisciplinary approach to patient care in the RSA (ANC 1994:45). The ANC National Health Plan (ANC 1994:45), indicates the importance the ANC places on mental health. They stressed the need to develop adequate and flexible mental health services in the

RSA at community level and ensuring multisectoral and integrated approaches to mental health services. The integration of mental health care and primary medical health care could enhance the quality of patient care. When the services were integrated, the overall cost-effectiveness of the health services improved (Nickels & McIntyre 1996:522). This study will investigate to what extent the physical and the psychiatric aspects of the patients were integrated by studying the referrals received by a psychiatric unit in a general hospital.

Psychiatric patients might be sent so far out lying specialised psychiatric hospitals for referrals and treatments. This could cause delays in the commencement of treatments and these moves might be frightening for the patients. It could be difficult for the patients' families to get to these hospitals, thus the patients might not get their support. Collateral histories might be difficult or impossible to obtain. The transfers could be costly for the patients and their families, hospitals and health services (Asley-Smith 1991:18). This study will investigate the rate of transfer of patients to a specialised psychiatric hospital amongst referrals sent to psychiatric units in a general hospital.

During 1993, only 12,4 percent of registered nurses in South Africa were registered psychiatric nurses – thus most psychiatric care was provided at secondary levels, namely treatment, and many patients did not receive the care they needed (Uys & Middleton 1997:68). However, this trend is changing with the implementation of Regulation R425 of 1985, where all nurses receive theoretical and practical psychiatric training during their four-year basic training. According to Green (2000), 27,5 percent of registered nurses were also registered as psychiatric nurses in 1999.

Nickels and McIntyre (1996:522) maintained that it could be unrealistic to assume that general medical practitioners could adequately attend to all psychological aspects of their patients' care. General practitioners need to refer patients to psychiatric services when such care would be required. This study will examine the rate of referrals from various departments to a psychiatric unit in a general hospital.

Olfson's (1993:277) study done in the USA, showed that only a small number of general

hospitals provided the full complement of services, including psychiatry. In these hospitals the patients might not receive holistic care. Lindeke (1998:213) concurs with this in that she records that health care providers need to work together in planning, implementing and evaluating health care to ensure care of a high quality which has a holistic approach. McCloskey (1994:157) also concurs stating that interdisciplinary teams must be promoted to facilitate quality and holistic care. Shoultz (1997:26) notes that interdisciplinary collaboration fosters healthier communities. This study examined the utilisation of a psychiatric service in a general hospital.

1.3.1 Statement of the research problem

To treat patients correctly they should be approached holistically and for this reason psychiatric services are incorporated in general hospitals. However, holistic care cannot be guaranteed in situations where the correct referral procedure is not followed and the available services utilised incorrectly and/or inadequately.

1.4 AIM OF THE RESEARCH

The aim of this research was to investigate the referral practices of health care providers to a psychiatric unit in a general hospital in the Western Province. The results of the study could be used to recommend improvements in referral practices from various hospital departments to the psychiatric unit.

The purpose of this research was to analyse the referrals received by a psychiatric unit in a general hospital during January to June 2000. This could then assist in examining the extent of the use of the unit and whether the unit was used effectively. The study analysed the referrals to determine who sent the referrals. It also analysed the biographical details of the patients referred to determine the biographical statistics of the patients. It analysed the content of the referrals, namely whether there were sufficient details about the patients' conditions and the requests for service by the referral sources to assess the appropriateness of the referrals. It also analysed the content of the feedback of the referrals to determine the

quality of feedback given to the referral source.

In the RSA, psychiatry has for many years been treated as a separate entity in medicine (Ashley-Smith 1991:1). With the new trend in holistic health care, psychiatry must be incorporated in all patients' health care plans (Granville 1993:96). This has led to the establishment of psychiatric units in general hospitals. Such psychiatric units should have inputs in all the wards and outpatient departments of the hospitals through maintaining good referral systems.

At the conclusion of this research, recommendations were made for further research (Bell 1993:157). Suggestions were put forward for improving the health care services referrals to the psychiatric units, which might also be used, with appropriate adaptions, in other hospitals.

1.5 OBJECTIVES OF THE RESEARCH

The objective of the study was to investigate the referrals received by a psychiatric unit in a general hospital in the Western Cape. Based on these research findings, recommendations were made for further research, and suggestions were provided for improving referrals in health care services.

1.5.1 What was the extent of utilisation of the psychiatric unit?

The questions' objective was to examine the biological profile of the patients referred, to see the ages, sex, marital status, employment status and race of the patients; to identify the extent to which each group was referred (see questions 3 to 10 of the checklist included as annexure B).

1.5.2 What was the source of referrals?

With this question, the objective was to determine which health team member referred the

most and least patients to the psychiatric unit in a general hospital. It also identified the departments which referred, or which did not refer (see questions 1 and 2 of the checklist – annexure B).

1.5.3 Were the referrals received by the psychiatric unit appropriate?

The objective of this question was to examine if the referrals were meant to be seen by the psychiatric unit or if they were inappropriately sent to psychiatry. If the referral was appropriately sent to psychiatry, the question further examined whether the referral was sent to the correct team member (see questions 13, 14 and 31 of the checklist – annexure B). A further objective of this question was to assess the number of referrals that were unnecessarily sent as urgent cases, and those that were not but should have been referred as urgent cases (see questions 19 to 21 as annexure B).

1.5.4 Was the unit being used effectively?

This question's objective was to assess whether the referrals had the desired results, such as whether the patient was seen by the psychiatric unit and given the requested intervention (see questions 22 and 23 of the checklist – annexure B).

1.5.5 What was the compliance rate?

The objective of this question was to determine how many of the referrals come for their appointment so that defaulting could be traced and measures instituted to increase compliance, if necessary (see questions 26 and 27 – annexure B).

1.5.6 How soon were the patients seen after referral to the psychiatric unit?

The objective of this question was to assess how quickly the patients were seen at the psychiatric unit after the referrals were sent. This could help in assessing whether the psychiatric unit had an effective system for accepting and seeing patients and whether the

unit was able to see patients urgently (see question 28 of the checklist – annexure B).

1.5.7 What were the diagnoses of the patients referred?

The diagnoses of the patients referred were monitored to assess the categories of patients referred to assess whether any group was significantly under or over represented in the referrals (see questions 32 and 33 of the checklist – annexure B).

1.5.8 What was the process of utilisation of psychiatric care?

The objective of this question was to examine what interventions were given to the patients who were referred to the psychiatric unit, such as referral with recommendations, tests, medications, therapy, admission, referral elsewhere or completion of forms (see questions 29 and 30 of the checklist – annexure B).

1.5.9 How did the psychiatric unit give feedback?

The objective of this question was to determine the level of feedback given to the referral source to monitor whether the feedback was adequate or whether more detailed feedback was required by the referring department/unit (see questions 36 to 38 – annexure B).

1.6 ASSUMPTIONS UNDERLYING THE STUDY OF REFERRALS SENT TO A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL

Assumptions evident in the study related to attitudes, interests, goals, beliefs and ideologies. A further assumption was that the time factor would not make an impact on the study.

Even among mental health professionals, there were few agreed upon modes or standards of treatment, or expected outcomes of effective psychiatric care (Aiken 1992:218). This allowed for much subjective analyses of treatment which was not avoided in the study, namely that the correctness of referral was assessed on the actions of the psychiatric team,

thus assuming that their action was correct. The assumption was made that the actions of the psychiatric team were always correct.

Assumptions underlying the study also followed from the assumptions in the Whole Person's Theory postulated by ME Rogers (George 1995:166), where it stated that nurses should look at the whole person as opposed to only selected parts. This theory postulates the assumptions that the human being is a unified whole, is more than and different from the sum of its parts, that the individual and the environment are always exchanging matter and that the person is comprised of all his life experiences. Thus the assumption that was made in the theory was that psychiatric input would have an influence on the health of patients. Further assumptions from this theory include that individuals reflect their wholeness and that human beings are characterised by the capacity for abstraction, imagery, language, thought, sensation and emotion (George 1995:167), and the assumption is that psychiatric care will influence the state of the patients' health because the patients are treated holistically.

Further assumptions in this study followed from the assumptions in the systems theory, namely that the interrelated elements in the theory's model can represent a model of humans and their environment and the exchange of matter between them (George 1995:167). Because of this exchange, the theory assumes that the individual is an open system, and thus the assumption was made that psychiatric input could and would influence the patients' health.

Using the two theories and their assumptions, the importance of viewing the person as a whole became apparent – not only his illness but also his reactions, environment and past experiences are important. This can be accomplished by using psychiatric nursing skills available from the psychiatric unit. The Whole Person's Theory also describes the necessity for nursing care to be aimed at promoting dynamic patterning of the whole human being including the individual relationship to self and to the environment so that the total patient as a human being can be developed (George 1995:175). The drawback of the Whole Person's Theory and its assumptions is that the terms are abstract (such as goals for the patient), value laden and are not clearly defined (George 1995:176). This, however, can be

overcome by discussing the goals of the patient's treatment with the patient, and staff should not impose their own goals and values on patients, but give them enough information for them to make rational and informed choices.

1.7 SIGNIFICANCE OF THE STUDY OF REFERRALS SENT TO A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL

The research into the referrals sent to psychiatric units in a general hospital is important because:

- Many patients (13,0 percent) in the RSA are sent to far outlying specialised hospitals for treatment, resulting in the delay in commencement of treatment, difficulty for family to visit and participate in treatment, and high costs for the patient and hospital (Ashley-Smit 1991:12). Referrals to a psychiatric unit in a general hospital could avoid this.
- There was a high relapse rate in the RSA due to the lack of primary intervention programmes which referrals could alleviate (Gagiano 1992a:311).
- Only complicated and treatment resistant cases should be treated at psychiatric hospitals and others should be referred to psychiatric units in general hospitals for consultation only (Abiodun 1990:273).
- Primary care physicians in the RSA might not be equipped to deal with the psychiatric problems that present in their practices, which could account for up to 75,0 percent of their case load (Gous 1992:315). Referrals to a specialised source should be one aspect of providing holistic health care.
- It is important to have a holistic approach to health care, this can be done through referrals to appropriate health disciplines, including psychiatry (Davis 1998:19).
- Only 2,0 percent of patients (who consult medical practitioners) that have a psychiatric illness are referred (Pillay & Subedar 1992:5), therefore more referrals should be made to the psychiatric unit.
- Depressive disorders account or more disability than do medical illnesses (Lyness & Caine 1993:910), therefore it is necessary to have a holistic approach to health care

and this can be achieved through referrals to appropriate health disciplines: an aspect to be investigated during this research.

1.8 OPERATIONAL DEFINITIONS USED IN THE RESEARCH REPORT

Appropriateness refers to correctness and suitability (Sykes 1992:34). In this study appropriateness related to the correctness of the referrals, namely whether the referral was sent to the correct team member and if it was sent urgently, when necessary.

Consultation-liaison is the structure or practice of a working relationship between specialists and primary health care staff to facilitate referrals between the various services and specialist (Gous 1992:315). It involves close working relationships between a mental health care professional and other health care professionals with the aims of providing mental health knowledge and skills in a non-psychiatric setting. It is a process of communication between two professionals (Uys & Middleton 1997:71). In this study it referred to the content of the referral (namely if there was sufficient information), and to the type of feedback provided to the referral source.

Effectiveness refers to the efficiency of the result or the production of the desired result (Waite 1994:202) implying whether the psychiatric unit brought the desired result. In this study it included whether the patient was seen and treated at the psychiatric unit.

Health is a state of spiritual, mental and physical wholeness; the person's pattern of interaction with his internal and external environment determines his health status (Wessman 1994:11). Here it incorporated the patients' physical and mental health.

Holistic health care entails looking at the total individual – responding to the fact that the human is a unified whole having individual integrity and being more than the sum of the different parts (George 1995:166). Again in this study it was used in the context of the patients' physical and mental health.

Primary health care (PHC) is accessible, comprehensive, coordinated and continuous health care provided by accountable care givers. In this study it was used to denote the first level of health care which is mainly given at a preventive and promotive levels (Stanhope & Lancaster 1992:761).

1.9 SCOPE AND LIMITATIONS OF THE STUDY OF REFERRALS TO A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL

The scope of the study was to analyse the utilisation of the psychiatric unit in a general hospital in the Western Cape from 1 January 2000 to 30 June 2000 The study also investigated whether the unit had been used appropriately for referrals from other hospital departments.

A limitation was that referrals to only one psychiatric unit in one general hospital were studied, limiting the generalisability of the results. The hospital was designated for military personnel, thus further limiting the generalisability of the research findings. The study was done for six months, thus also limiting the generalisability of the results. The study was a retrospective study and this limited the amount of further delving that could be done. The data was collected using records and thus limited the scope of the study in that data from observations and experiments were not included. The study did not show any data relating to the satisfaction of the consumer regarding the service received from the psychiatric unit. It also did not give data as regarding the relapse rate or recovery rate of consumers.

1.10 ORGANISATION OF THE REPORT

The report comprised the following chapters:

Chapter 1. Background information. In this chapter the reason for the research was explained. The background of the problem under research and the significance of the research was decided.

Chapter 2. Literature review. The chapter described the findings pertaining to the study in literature. Local and international literature sources were reviewed.

Chapter 3. Research methodology. This chapter described the collection method, the research population and sample. The benefits and drawbacks of the method of data collection were described. The reliability and validity of the checklist were examined.

Chapter 4. Presentation and discussion of data. The data collected was analysed, presented in tables and graphs.

Chapter 5. Research report. In this chapter conclusions derived from the data analyses were presented. Recommendations based on the conclusions of the study were provided. Recommendations for improvement of the service and for further research were also included.

1.11 SUMMARY

The reason for the research was explained, namely the necessity of treating the patient holistically and the importance of psychiatric inputs towards reaching the ideal of providing holistic care. The purpose of this research was explained, namely to investigate the utilisation of a psychiatric unit in a certain hospital in the Western Cape by studying the referrals the unit received from January 2000 to June 2000. The background of this research was explained, namely that it was observed that patients in general hospitals might not receive appropriate psychiatric care, either for accompanying psychiatric illnesses or to assist the patients in coping with their medical or surgical conditions such as cancer, amputations or dying.

The questions explored in this research included whether the psychiatric unit was being used effectively and which departments referred patients to the psychiatric unit. The next chapter will review national and international literature relevant to referring patients to psychiatric units.

CHAPTER 2

Literature review

2.1 INTRODUCTION

National and international reports relevant to the topic of referrals to a psychiatric unit in a general hospital were reviewed. Both theoretical literature sources (focusing on concepts, models and conceptual frameworks) and empirical literature sources (focusing on the results of various studies) were used (Morse 1991:56). Knowledge was gained during the literature review, providing a foundation on which this research was built, including the basis on which the checklist, used for gathering data, was developed.

2.2 PURPOSE OF THE LITERATURE REVIEW

The purpose of the literature review was to gather and understand available information and current knowledge on referrals to psychiatric units in general hospitals, and to describe current understandings of the questions in the study by examining related studies and

theories (Polit & Hungler 1993:91). The literature review also helped provide an important context for the study, namely establishing grounds for further research (Polit & Hungler 1993:91) and minimised unintentional duplication. It also aided with identifying and clarifying the research topic, namely the referrals received by a psychiatric unit in a general hospital and its related questions such as:

- Which disciplines referred to psychiatric units the most/least?
- Was the utilisation of psychiatric units effective?
- To what extent was the unit utilised?
- Were psychiatric units being utilised appropriately?
- What was the compliance rate of patients referred to a psychiatric unit?
- How soon were patients seen after referral to a psychiatric unit?
- What were the diagnoses of the patients referred?
- What was the process of utilisation of psychiatric care?
- What was the type of feedback given to the referral source?

The information gleaned from the literature review was used to explain and support theories in the study as well as verifying the significance of the research problems (Bell 1993:37). Further it assisted with the selection of the research design and in the construction of the measurement tools (Polit & Hungler 1993:91). The literature review was also important in identifying limitations and assumptions of the study and in exploring what further research would be needed, and it guided the researcher in overcoming them (Botes 1991:5). Although no exact study was found in the literature study, studies of a similar nature were studied to gain a broad background knowledge (Treece & Treece 1986:91). The literature review also helped to identify various methods of research and of analysing and presenting data. The literature study was conducted in areas of specific relevance to the study but also in areas of general interest to explore new applications of study methods and unresolved research problems (Polit & Hungler 1993:92). The literature study also helped to clarity the significance of the study in that it revealed data around areas relevant to the study.

2.3 SCOPE OF THE LITERATURE REVIEW

Both theoretical and empirical literature sources were used.

2.3.1 Theoretical literature resources

During the literature review concepts, research models and conceptual frameworks were studied. The Whole Person's Theory (Wessman 1994:10) was studied in order to gain an understanding of the importance of a holistic approach to patient care, and thus the necessity for referrals. A research model that was studied was the quantitative research approach (Botes 1995:18). This guided the researcher in the research methodology used, namely the analyses of the data collected. Conceptual frameworks of studies were also reviewed, including the studies done by Ashley-Smith (1991:13), Botes (1995:1) and Gagiano (1992c:79). This assisted the researcher with the presentation of the data.

Local and international literature was reviewed. Some of the local authors used were Ashley-Smith (1991:1), Botes (1995:1), Gagiano (1993:1) and Gous (1992:315). Some of the international authors used were Creed (1993:204), (UK); Jackson (1993:375), (UK); Morse (1991:56), (USA) and Stefanis (1990:531).

2.3.1.1 Concepts in theories

- **The Whole Person's Theory**

The concept expanded upon in the Whole Person's Theory was reviewed. A concept developed by ME Rogers in the theory is that human beings are a unified whole possessing characteristics that are more than and different from the sum of their parts (George 1995:166). This shows the need for patients to be viewed holistically, and that all aspects of their health need to be attended to and this can be achieved by appropriate referrals.

- **Systems theory**

The application of social systems theory to the family unit demonstrates the complexity of family functioning. Some critics of nursing education in the USA contend that there is a heavy emphasis on wellness and illness of the individual – within the nursing systems theory the health status of any family member affects that of all the other members because of the input the individual has on the family (Stanhope & Lancaster 1992:454). This stresses the need for patients to be referred for family therapy whenever any one member becomes seriously ill or faces crises such as an amputation of a limb.

Norris (1991:840) also noted that the influence of various factors on each other illustrated using the systems theory. This author explained the various factors that influence a person's health especially his/her mental health, namely cultural, religious, scientific, economic, political and social factors, using the systems theory. This also stresses the need for referral to a psychiatric unit when necessary, in order to succeed in providing holistic patient care.

2.3.1.2 Research model

- **The quantitative research model**

The quantitative research model was a framework for a study where the researcher aimed to measure, compare and analyse phenomena (Taube 1990:40). Research using this model was done by Robson in Taube (1990:44). The study examined the care given to 429 patients – the patients were referred to psychologists and seen for an average of 3,7 sessions. A comparison using a standardised rating scale of problem-solving skills was done with a control group. On analysing the results Robson in Taube (1990:44) found that all indices improved significantly and the amount of psychotrophic drugs taken by the patients decreased substantially in the research group. This emphasised the importance of appropriate psychiatric care, facilitated through referrals.

2.3.1.3 Conceptual framework

- **Botes' Functional Reasoning Approach**

This framework facilitates the application of knowledge for the purpose of improvement of the practice of the phenomenon being studied (Botes 1995:13). In this study the referral habits to the psychiatric unit in a specific general hospital were studied and the results and analysis thereof used for suggesting improvement pertaining to the referral system operating in the hospital concerned.

2.3.2 Empirical literature sources

Primary and secondary sources were reviewed.

2.3.2.1 Primary sources

Primary sources or original works (Burns & Grove 1999:106), were reviewed including works by the ANC (1994:45), Ashley-Smith (1991:1) and Gagiano (1993:1).

2.3.2.2 Secondary sources

Secondary sources, quotes and interpretations of one author by another, were also reviewed, such as quotes by Wolff in Roberts (1998b:29).

2.4 LITERATURE REVIEWED ON REFERRALS TO PSYCHIATRIC UNITS

2.4.1 Consultation-liaison

In 1902, Albany Hospital was the first general hospital in the USA with a psychiatric unit (Lewis 1992:2). Since then, the development of psychiatric units in general hospitals has influenced the growth of consultation-liaison in psychiatry in the USA (Lewis 1992:6). As

health care systems expanded, and became more sophisticated, increasing measures, such as consultation-liaison, were needed to ensure their coordination to provide an effective and comprehensive health care system. Health team members need to become aware of their limitations and others' skills to refer appropriately (Harris 1991:119).

The purpose of consultation-liaison is to facilitate education and sharing of knowledge between disciplines and to ensure appropriate therapeutic intervention by utilising each others' skills (Murray 1997:688).

Consultation and liaison are separate and distinct, but interdependent activities. Consultation occurs when an expert gives an opinion on a specific case, such as diagnosis, treatment and preventive measures. This is a time limited activity and contacts between both referral person and expert cease when the consultation is complete (Haber 1998:200). Consultation has two part, assessment of the patient and communication with the referral source (Gelder 1995:363).

The reasons for consultation are:

- ensuring input from a wide source of experts
- Fostering committed action due to shared ownership of solutions
- increasing accountability
- providing a holistic approach to patient care (King 2000:29)

Liaison is an ongoing relationship between (psychiatric) experts and other health team members where education and support of a general nature is the focus of the interaction (Deave 1995:362). One of the aims of liaison is to increase the skills of the general health care givers (Clark 1990:182).

The dissertation by Ashley-Smith describes the consultation-liaison service between general units and the psychiatric unit of a general hospital in the Western Cape (Ashley-Smith 1991:17). He described how initially, while the unit was being developed, patients were

referred to him by staff placing names in a book kept in the casualty department. Each morning he would see the patients referred to him during the preceding 24 hours. Due to the accessibility and presence of the unit, the referrals increased, as did the need for more staff, which was duly supplied. As the service grew, the need for an office and a more structured consultation-liaison system became apparent. A new referral system was implemented where the referring person would fill in a referral form and send it to the psychiatric unit via a messenger.

After consultation he would give written feedback to the person referring. To augment the liaison between psychiatric staff and general staff, the psychiatric team became involved in the in-service education programme, and also developed rapport with the staff on a one-to-one basis to encourage appropriate utilisation of the service (Ashley-Smith 1991:4), through increased awareness.

Throughout the literature review there was consistent reference to the fact that consultation-liaison was the key to an effective medical service. Gous (1992:316) stated that effective liaison among members of the team is essential for an effective service. Hart (1992:331) noted that although specialised units should remain separate entities at secondary or tertiary levels, they should still liaise closely to benefit from each others' expertise. According to Stuart and Sundeen (1995:854), effective communication was the key to a good consultation-liaison network, and could be accomplished through referrals and feedback.

Freeman (1990:4) recorded that in a study conducted in the USA, 70,0 percent of psychotrophic drugs were prescribed by non-psychiatrists, who needed training and support. This could be provided if effective consultation-liaison networks existed.

The importance of consultation-liaison services in the UK was explored by Granville (1993:96). He stated that because a large number of the patients in general wards were elderly and their morbidity for psychiatric illnesses was high, it was important to refer them to a psychiatric unit when appropriate. He also stated that many patients were treated from a physical perspective only, and their psychiatric and psychological condition might be left

unattended "because once having found an organic pathology, the physician looks no further" (Granville 1993:96). Schmitt (1992:33) concurred how important it was to have a good consultation-liaison service in operation to ensure that patients received appropriate care (initiated through referrals). This author elaborated that this was important with the aged who tended to have more than one illness and their symptoms were often vague or masked by other illnesses.

White (2000:12) indicated that consultation, initiated by referrals, was vital if the patient were to receive quality care. Starkey (1997:12) concurred with this noting that patients could learn skills and function at higher levels if treated by a multidisciplinary team who consulted and liaised with each other.

Schramm (2000:178) recorded that in a study done in the RSA, the response rate to referrals was extremely poor, only one medical officer gave feedback. The patient was sent back to the PHC team with no indication of diagnoses, further management or follow-up treatments. This showed that the consultation-liaison network had failed, and the patient might not have been receiving appropriate, continuing care.

The concept of three filters in the health system was proposed by Casey (1993:3). The three filters are the patient, physician and specialist. Casey (1993:3) noted how important it is for them to interrelate to receive or deliver optimal care through maintaining good consultation-liaison networks.

2.4.2 Total patient care

Nursing theories were reviewed especially, the Whole Person's Theory (Wessman 1994:10), to investigate the importance of inclusion of psychiatric care as part of patients' treatment, this in turn showed the need for referrals to psychiatric units (Poggenpoel 1994:51). Literature on community psychiatry and inpatient psychiatry showed that a psychiatric service in a general hospital facilitated total patient care (Gagiano 1992a:311; 33rd Subcommittee Mental Health Matters 1993:9).

Poggenpoel (1996a:60) stressed that the holistic aspect of each human being incorporated physical, social and emotional aspects. Carr in Naidoo (1994:68) also described the patient as a whole person, family and community member with physical, psychological, social and religious aspects, needing preventive and promotive, curative and rehabilitative care. This could be achieved through appropriate referrals.

According to Ashley-Smith (1991:15), there was evidence of a high prevalence of undetected and untreated psychiatric disorders in general hospitals in the RSA (Ashley-Smith 1991:15). This could mean that the patients might not be receiving total patient care. This could be overcome by involving appropriate members of the health team through referrals.

McCloskey (1990:181) stated from her studies in the USA, that nurses and physicians are concentrating their attention on particular parts of the body, such the as heart, and are seen as lacking interest in the whole person. This narrowing of scope was reflected in case reports of patients who were discharged from hospital without reasonable follow-up plans of care, especially psychological care. This was reiterated by Fehrsen (1993:404) when he stated that physicians were not focusing on the individual but on the disease, and thus neglecting the person suffering from a disease. A person centered approach did make a positive difference to the care the patient received. Sivik (1992:375) recommended that medical practitioners and nursing staff received education regarding the person centered approach to providing holistic health care.

Kendel (1994:657) quoted that approximately 2,0 percent of inpatients in the UK teaching hospitals were referred to psychiatric units. He stated that figures for USA hospitals were higher, but nowhere near as high as the reported prevalence of psychiatric morbidity in that country. He further stated that many doctors did not regard the management of psychiatric symptoms as an integral part of clinical treatment. However, Ito (1999:57) noted that there was an increased recognition of the importance of integrating physical and psychiatric care to ensure that patients received holistic care, seeing to the needs of the whole person. This was substantiated by Burns (2000:76) who indicated that multidisciplinary team approaches would lead to improved coping skills and decreased symptoms, thus enhancing holistic care.

Greenberg, MacGowen and Neumann (1998:298) showed how multidisciplinary health teams in the USA were able to provide drug users with appropriate and holistic care through referrals and consultation-liaisons.

2.4.3 Inpatient and community care

The focus of health care in developing countries has shifted from inpatient to community care, thus psychiatric units need to have efficient outpatient departments to function effectively within this PHC context (Gous 1992:3). An effective referral system would be indispensable in this context. According to Gagiano (1992a:311), early detection of psychiatric illnesses proved problematic in the RSA, resulting in a high incidence of serious psychiatric disorders with sequelae in the RSA. There would thus appear to be a need to train health care staff to become capable and motivated to render primary psychiatric health care services in the community (Gwele 1995:57). Such staff members could then be utilised in planning the patients' total health care, by referring to, and receiving referrals from them.

The first psychiatric outpatient services in the RSA were established in 1957. Outpatient departments (OPD) were developed at all large psychiatric hospitals by the 1970s and the inpatient numbers began to decrease, but psychiatry was still totally distinct from general medicine (Uys & Middleton 1997:10).

Table 2.1: OPD and inpatient statistics

OPD STATISTICS	INPATIENT STATISTICS
1973 6 000	-
1975 10 000	1975 27 000
1980 22 000	1980 22 000
1990 35 000	1990 18 000

In the RSA the movement towards primary health care (PHC) occurred in the late 20th century when it was realised that hospital centered health care services were not effective in promoting health. In 1978 the Alma Ata declaration (Uys & Middleton 1997:12) spurred on the emphasis on PHC through it's declaration of "Health for all by 2000". However, in the initial declaration of Alma Ata, psychiatric care was not included among PHC services (Uys & Middleton 1997:12).

Mental health skills and knowledge are applicable to all health care situations such as in general hospitals and in the PHC services. The advantages of including psychiatric health care in PHC service include that early detection and commencement of prompt treatment in the PHC service will be possible. If hospitalisation is necessary, a local professional and families can become involved in the treatment. A further advantage of PHC services was noted when deinstitutionalisation began; there were problems because the families were not trained to care for their psychiatrically ill members, thus problems in caring occurred – these could be relieved by support from PHC services (Uys & Middleton 1997:12).

According to Young (1999:85), the inpatient statistics for the major general hospitals in the Western Cape for 1999 were:

- Tygerberg 718 103
- Groote Schuur 651 047
- Victoria 92 523

For the major psychiatric hospitals in the Western Cape, the inpatient figures for 1999 were:

- Lentegeur 429 593
- Valkenberg 255 619
- Stickland 184 972

This shows the large inpatient numbers in both general and psychiatric hospitals in the Western Cape, and thus the need for good referral systems and effective consultation-liaison

systems between all health related disciplines.

2.4.4 Non-referral to psychiatry

The ANC (1994:45) stated that patients in the RSA were not referred to psychiatry because care was fragmented and generally poor facilities existed for comprehensive health care in the RSA. Ashley-Smith (1991:4) showed a contributing factor to non-referrals to psychiatry in the RSA was the inaccessibility of psychiatric units because they tended to be in far outlying places. Calitz (1992:428) concurs, stating that the problem was that psychiatric services in the RSA were mainly centred in the urban areas leaving the rural areas underserve. He has seen a corresponding decrease in referrals to psychiatry in the rural areas due to poor availability of psychiatric services.

Levenstein (1994:303) noted that non-referral to psychiatric units was due to the lack of patient centeredness; physicians and nurses needed to be aware and trained that patients are multifaceted and need holistic care. If this did not occur, they would not refer patients to psychiatric units. Poggenpoel (1992:47) reported that physicians did not take patients' psychiatric symptoms seriously and therefore did not always refer patients when necessary. Silverstone (1996:43) stated that non-referral could be due to a lack of detection of psychiatric illnesses by physicians. His study in the USA shows the high rate of psychiatric illnesses in medical patients, namely 41,0 percent, but only 27,2 percent of the patients were diagnosed.

Clement (1999:376) recorded in his study done in France, that the study population (aged over 60 years) had a high prevalence (58,0 percent) of depression, yet there was a low number of psychiatric referrals. This was due to the lack of detection of depression by physicians and a reluctance by patients to accept referrals to a psychiatric units. This was reiterated by Petersen (1998:196) stating that it was important that PHC personal be trained in the identification and referral of patients with psychiatric disorders.

Carney (1998:1594) noted that a reason for practitioners not referring to psychiatry in the

USA was that specialist care was very expensive and thus unaffordable to a large group of patients. Pollack (1998:357) concurred with these findings when he stated that doctors tend to minimise referrals to specialists, including psychiatrist, to attempt to reduce costs for patients. White (1999:67) also recorded that the reason why health care providers did not refer to specialists (including psychiatrists) was due to the high cost of treatment by specialists.

Flaherty (1992:585) stated that referrals to psychiatric units decreased if the unit was not promoted nor advertised to medical personnel in the area. The way the unit was presented and what if offered directly related to the amount of referrals it received. The rest of the health team should be informed about the skills and the scope of the psychiatric unit. They would then be more likely to refer more frequently and appropriately (De Ville-Almond 2000:22). According to Berk (1998:300), general health practitioners would be more inclined to refer patients to psychiatrist if they could witness marked improvements in referred patients' conditions. This would only be possible if the psychiatrists provided feedback about these patients' progress to the referring general practitioners.

According to Huebscher (1997:163), writing a prescription was easier and less time consuming than patient education and working with patients to gain their compliance concerning a referral to a psychiatrist, thus many health practitioners did not refer patients to psychiatrists.

2.4.5 Non-compliance of referrals

According to Gagiano (1992b:361), in the RSA, the reason for non-compliance, or even not seeking psychiatric help at all, was due to the stigma of having a psychiatric illness, or of being treated in a psychiatric unit. This stigma needs to be broken down and staff need to be aware of the effects of the stigma when referring patients. This was corroborated by Vazquez (1992:495) as he stated that in Spain, community attitudes and social pressures inhibit people from seeking help for mental disorders. Counselling and explanations should be given by the physician to patients at the time of these referrals, to increase compliance.

Bennett (1991:23) stated that 20,0 percent more patients in the UK would comply to treatment at a general hospital than would do so at a psychiatric unit, therefore practitioners were reluctant to refer patients to the psychiatric unit. This could be overcome by reducing the stigma of psychiatry through education of the public and health care personnel. This was elaborated on by Kaminski (1999:37) who indicated that advertising and education, fostering favourable attitudes to psychiatry, should increase compliance. Kaminski (2000:28) further stated that stigma was still a major factor prohibiting patients from going for psychiatric care, as shown in his study done in Scotland. He also stressed the need to educate the public and health team members about mental illness. The University of Philadelphia (in the USA) took steps to accomplish this by introducing a four-year master's programme in medicine emphasising holistic care (Erasmus 1997:179).

Kincheloe (1997:1078) reported that when a psychiatric hospital closed down in Vermont (in the USA), the psychiatric unit in the general hospital took over the care of the patients previously treated at the closed-down hospital. The psychiatric community-based units enhanced the health centre's ability to provide a higher quality and more holistic health care service. Compliance by the patients increased significantly due to the decrease in the stigma of no longer being cared for at a psychiatric hospital, but at a general hospital. Mavundla and Uys (1997:3) found that 90,0 percent of nurses in general hospitals held a negative attitude towards mentally ill patients in Durban in the RSA. This affected patients' compliance with referrals. However, thus authors stated that this could change with the introduction of psychiatry into the basic nursing curriculum in the RSA.

Ntongana (1996:69) recorded in a study done in the RSA which indicated that the main reason for non-compliance was the poor availability of clinics, poor accessibility of clinics, negative effects of medication, poor education regarding the necessity of treatment and the attitude of the staff at the psychiatric units. She noted that the stigma of psychiatry played only a minor role and that family attitudes to treatment had virtually no effect on compliance.

Non-compliance may be due to cultural interpretation of illness (Haegert 1996:82). She related how some people would "make beer, visit a diviner, ask elders, have a family

conference, use 'muti' or herbs, ask the ancestors or go to a 'sangoma'" rather than go to a health service, including psychiatric units. Sartorius (1997:67) stated that PHC was the preferred way of organising health care in all countries of the world. The services should be acceptable and accessible to all, namely to adults, children, the elderly, male and female. The services also needed active inputs form individuals and their families. Kendel (1994:657) reported that a psychiatric department which is fully integrated within a general hospital is more likely to have high utilisation and compliance rates. When a close liaison is established and maintained between general and psychiatric units, staff are more aware of, and confident in the psychiatric unit's treatments and results.

According to Declercq, Paine, Simmes and De Joseph (1998:190) non-compliance was due to poor access to psychiatric units, they were either too far away or too expensive to access. O'Dowd (2000:14) substantiated this by stating that accessibility and convenience increased compliance in the UK. Lee (1999:711) stated that one of the main reasons that patients did not comply with referrals in the RSA was that the treatment was too expensive (both psychiatrists' visits and medication were unaffordable). It was also substantiated by Whitelaw and Warden (1999:135) where they recorded that patients' failure to comply with referrals was due to the cost (or anticipated cost) of the medication). According to Armstrong (1999:42), non-compliance with referrals could be due to the patients' anxiety about taking addictive medication or medication with side effects. Counselling and alternative medication, such as cheaper generic medicines, must be offered where possible.

A characteristic of many psychiatric illnesses, include the patients' inability to comprehend that they are ill. If this was a reason for non-compliance, it could be overcome by building a good rapport with the patient, enlisting the help of family members and by constant education of patients, especially when in remission.

2.5 CURRENT UNDERSTANDING OF THE QUESTIONS IN THE STUDY

Information regarding the questions investigated in the study was reviewed in local and international literature to gain insight into the current understanding on the study topic of

referrals received by a psychiatric unit in a general hospital, and to be able to make comparisons between previous studies and his research.

2.5.1 What was the extent of the utilisation of psychiatric services?

Blanco (1999:445) stated that in the USA chronically ill patients and economically disadvantaged patients tended to have complex mental health care needs. However, these patients were also less inclined to seek mental health services, and to comply with treatment.

In Koenigs' study done in the USA (Koenig 1997a:1369) it was revealed that nearly 60,0 percent of depressed hospitalised patients were not treated. Furthermore, 50,0 percent received benzodiazepines without clear indications for prescribing these drugs, and 45,0 percent received inappropriate antidepressants, often given at subtherapeutic dosages. He concluded that greater use of psychiatric consultants would be helpful in improving patient management. He also noted that psychiatrists were only consulted by 13,0 percent of the patients who participated in this survey.

Mkize (1998:33) described in her study done in the RSA, that 50,0 percent cases of severe depression were not diagnosed by physicians. The physicians' focus was on the physical illnesses of the depressed persons, causing them to miss signs of depression. She also noted that depression could be missed if it occurred in individuals who were known to their health care providers because of previous or current physical illnesses.

Ward (1999:51) stressed the importance of implementing appropriate and well-defined changes, because changes in health care settings could cause uncertainty among clients decreasing the utilisation of the service. This could leave many patients without the care they required.

In a further study done by Ward (1999:52), he reported that mental health nurses in the USA perceived themselves as having the necessary skills but that they were not utilised properly.

According to Roberts (1998a:15), the recognition and referrals of mental health problems was more likely if health staff had training and supervision, and were familiar with the referral processes. Tyrer (1993:2) recognised that general practitioners who dealt with all forms of physical and mental illnesses, were likely refer patients/clients appropriately for mental health assessment and treatment.

Regel (1995:1052) stated that most, if not all, mental health services in the USA provided liaison cover in the form of a registrar who would have contact with accident and emergency departments and general medical wards for the assessment of deliberate self harm. Despite this, the liaison was not utilised to its full potential.

Colligham (1999:399) recorded that in the UK, 20,0 percent of inpatient referrals to psychiatry were from the over 65 year age group. Since at least 50,0 percent of inpatients were older than 65, a great number of elderly patients not referred to psychiatry and thus did not receive the holistic care they required.

Uys and Middleton (1997:19) stated that one out of every five people in the RSA would suffer from a mental disorder at some stage(s) in their lives. These authors maintained that mental illnesses were being taken more seriously because diagnoses were more scientific and less vague (through the use of the Diagnostic and Statistical Manual 4 Revised (DSM4R)) and because new methods of studying the brain were being used such as CAT scans (Uys and Middleton 1997:43).

2.5.2 What was the source of referrals?

Creed (1993:204) stated that the psychiatric units were underutilised in the UK and that referrals mainly concerned patients with self-poisoning. Further Creed quoted that 20,0 percent of medical patients in the UK had psychiatric problems, yet only 1,0 percent were referred to psychiatry. While he acknowledged that not all 20,0 percent needed to be referred, he recorded that a significant percentage above the 1,0 percent needed such referrals. He attributed the lack of referrals to the low priority accorded to psychiatry by

medical practitioners as well as the possibility that their commitments, beliefs, trust, understanding and interests lay outside the field of psychiatry. Creed also reported that more patients were referred to psychiatry when psychiatric unit were nearby other health care facilities, such as general hospitals (thus visible and convenient) and quite active. Good education and marketing enhanced the utilisation of psychiatric units.

Gous (1992:316) supported these overseas research findings with statistics gathered in the RSA – he stated that 50,0 percent of the patients who consulted medical practitioners suffered from a psychiatric disorder, yet only 2,0 percent were referred. The majority were treated with medication only, and no attention was given to unresolved psychological issues not to the improvement of patients' coping skills. Appropriate referrals to psychiatric units could help patients to enhance their coping skills.

A study done in the USA by Koenig (1998:871) indicated that depression was present in one third to one half of hospitalised patients over the age of 60. This population group constituted a large potential source of referrals because more than 70,0 percent of these depressed patients were either untreated, or treated inadequately.

Hensing (1998:251) stated that patients in the UK did not often demand psychiatric services, thus self referral or pressure by the patient on the physician to refer to psychiatry was uncommon. This concurred with Barker (1997:33) who also noted that due to the stigma of psychiatric illness, patients were reluctant to go to psychiatric units and thus rarely requested referrals.

Parades (1998:15) noted that in the USA there was a major drive from long-term residential hospitals to outpatient treatments. This led to a dramatic increase of referrals of patients with psychiatric problems to outpatients at psychiatric units at the general hospitals. Statistics quoted indicated that in 1977, 77,0 percent of psychiatric care was inpatient-based, whereas in 1999, 73,0 percent of psychiatric care was outpatient-based. In Farragher's (1998:74) study done in Ireland, found that accident and emergency units referred 79,0 percent of patients while 21,0 percent of these referrals came from the hospital wards. No referrals

came from outpatients.

Wolff (1997:342) stated that almost all of the homeless patients who were seen in psychiatric units in the USA were referred by casualty departments of general hospitals. He observed, however, that casualty department did not refer "sufficiently or appropriately".

2.5.3 Were the referrals received by psychiatric units appropriate?

Gagiano (1993:11) did not comment on the appropriateness of the referrals in the RSA. Van Rensburg (1992:418) noted that in the subspeciality of forensic psychiatry, 52,0 percent of referrals to a RSA psychiatric forensic unit had no psychiatric illness, thus were referred inappropriately. This, however, differs vastly from a study in the USA where only 0,7 percent of referrals to a forensic unit had no psychiatric illness. Thus only 0,7 percent of referrals were referred in appropriately in the USA. Berard (1998:409) showed in a study of adolescent referrals in Cape Town, that 78,3 percent of referrals from trained sources were appropriate and that 75,6 percent of referrals from non-trained sources were appropriate. In Vazquez' study done in Spain (Vazquez 1997:529), between 31,5 percent and 33,5 percent of patients seen in the primary care services had mental illnesses. However, only from 10,9 percent to 15,0 percent were referred to psychiatric units. He did not comment on the appropriateness of the referrals that were sent to the psychiatric units.

In Wolff's study (Roberts 1998b:29) in the UK, psychiatric units were often consulted only "when time got tough". These emergency referrals were usually inappropriate because they were often too late. Education of the general staff about the role and function of the psychiatric unit, and the early signs and symptoms of psychiatric illnesses, led to increased referrals done more appropriately and before the psychiatric illnesses progressed too far.

2.5.4 Were the referrals adequate?

Ashley-Smith (1991:10) recorded that referrals initially written in a book and prior to education of staff were inadequate. These referrals lacked the necessary detail of the

patients' histories and the referrals did not state whether the referrals were urgent or not. Once education was provided and specific referral forms were used, more and more of the referrals were done appropriately.

2.5.5 Was the utilisation of psychiatric units effective?

Sharfstein (1997:723) stated that there were no standard rules for cost effective analysis for health care in the USA. It was a difficult concept to measure because health and recovery could not easily be measured in terms of cost or time.

Gagiano (1993:11) described how a well-run psychiatric unit in the Orange Free State Province of the RSA prevented the need for a major psychiatric hospital to be built in that province because psychiatric inpatient admissions dropped from 120 to 20 per year. This was attributed to the fact that outpatient referrals to the psychiatric unit increased from 20 000 to 72 000 per year over a five year period. This enabled preventive and promotive, curative and rehabilitative work to be done with large number of patients, decreasing the need for inpatient admissions.

Farmer's (1992:717) study done in the UK noted that general practitioners were more likely to refer patients to psychiatry if the patients had previous psychiatric labels or diagnoses. The basis for referrals was thus inappropriate and referrals were made inappropriately to psychiatric units. Thus these psychiatric units were used ineffectively because patients were referred because of their histories of psychiatric treatment, not because of their actual health needs at the time of the referrals. Dolinar (1993:14) recommended education of all health staff regarding the scope and functions of psychiatry to improve the effective utilisation of psychiatric units.

Olfson (1999:451) observed that in the USA shorter visits tended to be provided to older patients and patients with psychotic disorders. This implied that less psychotherapy was done and more psychotrophic medications were prescribed for these patients.

Perkins (1998:994) stated that a study of geriatric inpatients in the USA revealed a much higher rate of diagnostic accuracy for depression among referring doctors if the doctors liaised with psychiatric specialists. Thus if the consultation-liaison process was in place, patients apparently received more effective care.

Fontana (1997:762) reported that in the USA short, high input admissions were preferable to long stays (exceeding one year) for the optimum care for patients with post-traumatic stress disorder (PTSD). The patients showed improvements in social functioning and reductions of symptoms during short-term stays. Long-term stays led to decreases in social functioning and increased symptomatology. Thus referrals of patients with PTSD for short-term inpatient care proved effective.

Sokhela (1998:9) stated that for successful rehabilitation, there should be close cooperation between health, welfare, labour and the communities so that the services of these sectors could be integrated within a PHC Clinic. Wolff (1997:341) reiterated this when he noted that psychiatric units should become included in patient care together with all other health disciplines, such as social workers, to provide holistic care.

Bender (1992:29) stated that elderly people often have non-specific illnesses and also several complaints. Those who were referred to psychiatric units had the best chance of receiving holistic health care.

Rosenheck (1998:459), in his study in Connecticut, stated that patients referred to a psychiatric unit from a medical or surgical unit showed fewer symptoms, had higher levels of functioning and expressed greater levels of satisfaction with their care. Rosenheck also stated that treatment at psychiatric units significantly reduced the need for inpatient psychiatric care. Agbayewa (1990:38) noted in his study done in Canada, that depressed patients who had been managed in the community by non-psychiatric personnel with supervision by a consultant psychiatrist had fewer symptoms, a higher level of functioning and received more appropriate treatment. Thus the intervention of psychiatric units proved to be effective in these cases.

2.5.6 What was the compliance rate of patients referred to psychiatric units?

In Ashley-Smith's (1991:10) study done in the RSA, he recorded that compliance rates improved once better rapport had been established between the general staff and the psychiatric staff, because the general staff were more likely to encourage the patient to attend. No specific statistics were supplied by this author to substantiate this claim.

2.5.7 How soon were the patients seen at psychiatric units after referral?

In Ashley-Smith's (1991:8) study, he recorded that patients referred to the psychiatric unit from the casualty or inpatients departments were seen within 24 hours. He did not give statistics for outpatient referrals.

2.5.8 What were the diagnosis of the patients referred?

In Johnson's study in the USA (Denton 1997:1038), there was a great increase of patients referred between the ages of 40 to 60 years who had been in the Vietnam War and suffered from PTSD. There was no mention of who referred the patients nor about their compliance with treatments.

In a study by Tardiff (1997:88) in the USA, it was shown that there was an increase in patients who were referred to psychiatric units with violent outbursts during the period 1985 to 1998. Since the study by Whitney in 1985 in Tardiff (1997:92), the episodes of violence in women has risen by 150,0 percent and in men by 50,0 percent. The reasons given for this increase was the general increase in violence in the American society and the increase in drug abuse.

Co-morbidity was evident in the study done by Grillo (1997:1305) in the USA. He noted that there was a significant co-morbid occurrence of drug abuse and borderline personality disorder. Wolff (1997:341) stated that approximately one third of the homeless population in the USA had a combination of mental illnesses, the majority being alcohol/drug abuse and

schizophrenia. A study done by Holloway in Lichtigfeld (1994:5) showed that 53,0 percent of patients who abused drugs had an accompanying mental health disorder, such as schizophrenia or major depression. The prevalence of co-morbidity was concurred by McKerrow (1999:18) who noted that many people consulting their general practitioners with physical illnesses, had key concerns about mental health problems. Goldberg (1995:271) also noted that psychiatric problems had an increased prevalence in patients with medical disorders.

Table 2.2: Association of psychiatric symptoms with medical conditions

FATIGUE	DEPRESSIONS
Insomnia	Manic psychosis
Chronic medical conditions, for example arthritis	Depression
Myocardial infarction	Depression
Parkinson's disease	Depression Organic brain syndrome
Stroke	Depression Organic brain syndrome
Alzheimer's disease	Psychosis
Cancer	Depression
AIDS	Depression Psychosis

In Olfson's (1996:1613) study in the USA he noted that in public hospitals 31,7 percent of patients had schizophrenia, whereas in non-public hospitals 21,7 percent of the patients had schizophrenia. He recorded no difference in the amount of substance abusers in public and non-public hospitals.

Szabo's (1994:35) study in the RSA showed that patients with bipolar disorder presented with manic relapses most frequently during the spring months, whereas depressive relapses occurred most frequently in winter. He also noted that patients with seasonal affective

disorder presented most frequently in winter.

A one year prevalence study done by Greenfield (1997:1391) in the USA showed the prevalence of depression to be 10,3 percent (7,7 percent in males and 12,9 percent in females), yet 50,0 percent of these patients were not treated. This was in contrast with the study done by Koenig (1997b:1379) in the USA, where he found the prevalence rate of depression to be 21,0 percent. Gater (1998:405) reported in his study done in Manchester in the UK, that more females present with depression, but more men present with anxiety disorders. Carter (2000:94) reported that in New Zealand, women were twice as likely to suffer from depression as men. As women accepted referrals more readily than men, more referrals to psychiatric units were females. In a study done by Wolff in Roberts (1998b:28) in the USA, he observed that among inpatients in a surgical ward, depression or "worried behaviour" was the most likely reason for referral in that group of patients. Bell's (1991:139) study showed that somatisation was the most common way for psychiatric disorder to be presented in a surgical ward.

Henderson's (1998:105) study in the USA examined the prevalence of mental illness in various population groups. In low socio-economic groups schizophrenia was most prevalent. She also noted that in general, mental illnesses were two to three times more prevalent among low socio-economic groups. She noted that with regard to age, depression was no more common in the over 65 age group, but it was more severe. Children in places of care tended to have a higher prevalence of mental illness. With respect to sex, 19,5 percent women and 12,3 percent men were dependant on alcohol and drugs. No difference in rates of psychoses were noted between women and men, but among men the onset of psychoses tended to be earlier and the outcomes were poorer. Thus the use of long term facilities and medications were higher for men. The prevalence of non-psychotic disorders was lowest among married patients. Service users for all mental illnesses were usually unmarried. Mental illnesses in the African-Carribean ethnic group was twice as high as in the Anglo-American population. She also found that unemployment was the most effective predictor of psychiatric admission. Psychoses showed little urban/rural difference. However, manic depression tended to be more prevalent in the rural areas and schizophrenia higher in the

urban areas. This was corroborated by a study done in the RSA by Uys, Dlamini and Mabandla (1995:22) when they stated that 58,0 percent of the psychiatric patients came from rural areas.

Brooking and Ritter (1992:22) stated that most referred patients were referred for secondary level care (treatment) or tertiary level care (rehabilitation and after care). Very few patients were referred for primary level care (preventive and promotive health).

In the study done by Le Grange (1998:168) in the RSA, it was shown that eating disorders were not primarily Western Caucasian illnesses. It was one of developed or developing countries, thus greater percentages of patients of developing and developed countries should be referred to psychiatric unit for eating disorders.

Morar (1998:12) stated that in a study done in the RSA, 35,0 percent of patients presenting with psoriasis (a chronic, pailful skin condition) had depression and required psychological management. Once both dermatological and psychological care had been given, patients showed marked improvements. This study did not report about the prevalence of psoriasis and depression in the RSA.

Hilton (1998:66) reported that 20,0 percent of over 65s in the USA suffered from depression and 50,0 percent of patients in geriatric wards had depression. Ellis (1995:31) concurred that depression was the most common problem of patients seen in primary care – a study done in the RSA showed this to be 27,0 percent of the patients coming to primary care. But none of the patients indicated that depression was the reason for the visit. Many patients who reported to casualty departments as "accidents" were in the middle of major life crises and were potentially depressed and needed psychiatric referrals.

In the study done by Kim and Buschmann (1999:235) in Chicago, it was revealed that 10,0 percent of people over 65 years of age had Alzheimer's Disease, and thus a significant number of these patients should have been referred to psychiatric units. Gillman (1996:135) noted that black Africans did not present with Alzheimer's disease, mainly due to their lower

life expectancy. But as their life expectancy increased, this disease could become more prevalent and appropriate referrals of patients and their families or care givers would become necessary to ensure appropriate and holistic care.

Mhlongo and Peltzer (1999:72) did a study on the youth of the RSA. The results showed that parasuicide among youth had increased dramatically in the last 30 years. They reported that 17,7 percent of general hospital admissions in Durban were patients who attempted parasuicide.

2.5.9 Who referred the most/least patients to psychiatry?

In Ashley-Smith's study of a psychiatric unit in a general hospital in the Western Cape (Ashley-Smith 1991:14), two thirds of the referrals were from medical or surgical wards. This was in contrast to Gagiano (1992a:312) who showed that in the RSA, 50,0 percent of the patients who consulted general medical practitioners suffered from psychiatric disorders but only 2,0 percent of these patients were referred to psychiatry. Jackson (1993:378) found similar results in his study in the UK, and noted that general practitioners initially only consulted with the psychiatric team after they had gained confidence and established rapport with the psychiatrist before they handed over their patients for psychiatric treatment. Taube (1990:39) related that primary care providers in the USA only recognised 2,0 percent to 16,0 percent of psychiatric disorder and thus their referral rates to psychiatry were very low.

Carney (1998:1594) reported in his study in the USA that psychiatrists commonly referred patients to specialists psychiatric hospitals with inappropriate use of drugs (prescription and non-prescription), while internists were more likely to refer patients with physically related problems, such as heart attacks for management of stress or anxiety.

Wuerker and Keenan (1997:105) noted in the USA, that if a patient belonged to a medical aid scheme and needed psychiatric care he would be more likely to be referred to a psychiatric unit than a patient who needed psychiatric care but did not have medical aid. However, he stated that this was probably not unique to psychiatry but occurred in all

specialities. Nevertheless, it was worth noting that there was a sector of the population who were not receiving psychiatric care.

Creed (1993:204) found in this study in the UK that oncologists and obstetricians tended to have the best consultation-liaison service. He did not give specific data. His study showed that oncologists tended to refer to psychiatric units more often than any other group of medical specialists.

Monkley-Poole (1995:238) stated that research had not specifically commented on whether a community psychiatric nurse aligned to a general practice had any effect on the number of referrals sent to a psychiatric unit by that practice. Bennet in Monkley-Poole (1995:239), however, stated that general practitioners were more satisfied with psychiatric units than social workers, and thus referred more persons to psychiatric units, but these referrals were not always appropriate.

2.5.10 What was the process of utilisation of psychiatric care?

The process of utilisation of psychiatric care occurs in three phases as described by Roberts (1998a:16), namely input, throughput and output.

2.5.10.1 Input

Input was the assessment received by the patient from the psychiatric team; this could be direct or indirect (Roberts 1998a:16). Direct input referred to patients receiving an assessment from a specialist psychiatrist doing a mental state examination after the psychiatric unit received a referral for that patient. Indirect input referred to the general health team having a consultation with the psychiatric unit about a case, but the psychiatric staff not seeing or evaluating the patient. Indirect input could also be in the form of education on psychiatric issues to the general staff by the psychiatric staff. Support, supervision, and feedback by the psychiatric staff to the general staff were also examples of indirect input.

2.5.10.2 Throughput

This referred to the treatment the patient received either as a result of direct or indirect input (Roberts 1998a:16). The psychiatric staff might advise treatment which was then instituted by the general staff or the psychiatric staff could take over the management of the patient and institute treatment, such as therapy or medication. The general staff might institute treatment after gaining knowledge from educational input from the psychiatric staff, namely feedback given not regarding a specific patient, but input on a general basis. To provide an optimal contribution to the patients' health, psychiatric staff needed to respond promptly to requests for consultations to prevent sequelae and to develop harmonious working relationships with colleagues (Kendel 1994:657).

2.5.10.3 Output

This was the result of interventions and treatment, namely the resolution of symptoms, the containment of symptoms or the prevention of further symptoms (Roberts 1998a:18).

This process started with the initial referral of the patients or the close liaison through support and education of general staff by psychiatric staff.

The relationship between the general staff and the patient was through general physical assessments and treatments. The relationships between general staff and psychiatric staff were affected by professional education and consultation/liaison. The relationships between psychiatric staff and patients were influenced by mental health education and specialist treatment (Roberts 1998a:18). Consultants were viewed as experts who had been selected to share their knowledge and experiences (Rosenkoetter 1995:183) (figure 2.1).

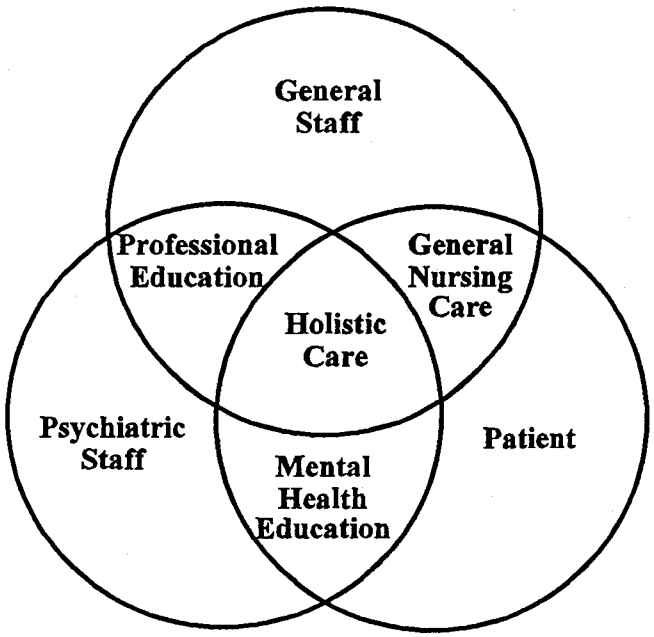

Figure 2.1

Relationships in the health team

2.5.11 Could the referrals have been improved?

In the study done by Ashley-Smith (1991:8) in the RSA referrals, previously placed in a register, were more fully recorded when a referral from was instituted. This improved referrals in that more details were received by the psychiatric unit. In turn, the psychiatric unit tended to give more regular and more detailed feedback to the referring departments. Inpatient referrals tended to be verbal, thus limiting the improvements resulting from better written referrals and records.

2.5.12 How did the psychiatric unit give feedback?

In Ashley-Smith's (1991:9) study, the psychiatric unit initially gave feedback verbally or not al all. Once the new referral system was instituted, the psychiatric unit responded in writing. If the patient was an outpatient the completed referral letter would be sent back to the referral source. If the patient was an inpatient (where often no referral letter was sent), the feedback was given in writing in the patient's notes and verbally to the nursing staff on duty on the

ward. The feedback thus appeared to be appropriate.

2.6 RESEARCH FINDINGS ALREADY IN USE

The dissertation of Ashley-Smith (1991:1) described the need, structure and difficulties of providing a psychiatric service in a general hospital in Cape Town in the RSA. He described the care of the psychiatric patient in the general hospital as a "clumsy and trouble laden process" and continued with a description of an in-house psychiatric unit in a general hospital in the Western Cape and how it provided an effective service to the psychiatric patients in the general hospital. He stressed the need for staff education about the utilisation of the unit and the benefits of the unit. Creed (1993:204) stated that, in the UK, poor consultation-liaison services between medical and surgical units of a general hospital and the psychiatric units were due to the low priority given to psychiatry. He observed improvements in the liaison between units when the psychiatric units gave in-service education and became more visible and active units.

Gossage (1990:31) confirmed that in cases where women were sent to psychiatric units when diagnosed with breast cancer, they showed fewer signs of depression and anxiety, and coped better with their illnesses. Jackson (1993:375) stated that the movement of the health care focus from the hospital to the community setting created the need for changes in the organisation and the utilisation of the various health services in the UK. He described how consultation/liaison between units made this transition smoother.

Gagiano (1992a:311) related that for many years psychiatric services in the RSA were rendered mainly at tertiary level, which was expensive and frequently led to permanent sequelae (if promotive and preventive measure are not provided). He further described how high relapse rates and poor motivation due to stigmatisation were prevalent in tertiary care as well as the fact that patients were far removed from their social and family systems. He showed how these hurdles were overcome and the psychiatric services became more effectively utilised. Gagiano (1992a:312) also reported that where a general hospital in the RSA incorporated a psychiatric unit, numerous benefits could be demonstrated, including:

- admission rates decreased by 20,0 percent
- early detection and intervention of problems preventing chronicity and sequelae with prolonged, expensive treatment were curtailed
- patients were more inclined to seek and accept help form other health care team members at earlier stages of psychiatric illnesses
- stigma was reduced for patients seeking psychiatric care in a general hospital, compared to there receiving care at a psychiatric hospital
- the relapse rate of patients treated in such a unit was less than 15,0 percent
- pharmacy savings for psychiatric patients were 48,0 percent compared to prior to the establishment of psychiatric unit

Poggenpoel's (1996b:60) research emphasised that nursing care should not only focus on a person's physical aspect but also on the psychological, spiritual and social aspects. Where this was done, comprehensive care was given (Poggenpoel 1996b:60). Sibeko's (1995:15) research in the RSA revealed that psychiatric nurses, as members of the multi-disciplinary health team, used a goal directed approach to assist psychiatric patients in mobilising resources to promote and prevent and/or maintain their mental health as an integral part of their quest for wholeness with great success. This resulted in the improved physical and mental health of the patient. As revealed by fewer physical and psychological signs and symptoms.

Roberts (1997:101) noted that in the USA, consultation-liaison with psychiatry was well-established with casualty and oncology departments. This enabled these patients to receive holistic care through consultation and referrals. Nichols' (1995:231) research done in the UK depicted that in the general wards in a general hospital, the staff who received psychiatric training documented the improved care received by all patients referred appropriately to psychiatric units.

Bennett's (1991:377) research done in the UK showed the 20,0 percent more patients were willing to go for psychiatric treatment in a general hospital than in a psychiatric hospital. He described the improvement in referrals when the stigma of going to a psychiatric unit had

been broken through education of patients and communities. However, such education would be a time consuming process and might require many years to show any effect.

In describing consultation, Uys and Middleton (1997:71) explained that consultation is a process of communication between professional groups of people. They saw consultation as empowering to the consultee, who could accepts or reject advice given. The consultant strived to teach, so there should be less need for consultation (Uys and Middleton 1997:71). In order for the consultant to give the best advice, the consultee had to provide all the available information to the consultant. Consultants had a lot of work and responsibilities therefore the consultee should use their time judiciously (Uys and Middleton 1997:71). With referrals, the consultee transfers responsibilities to the consultant until the consultant refers the patient back. The consultee might have consulted the consultant prior to referral (Uys and Middleton 1997:71).

Fehrsen (1995:5) stated that in three research studies in the RSA, the person centred, holistic approach in PHC made positive differences to the patients' health status. Naidoo (1994:68) stated that the long standing doctor-patient relationships could have important benefits in reaching the goal of holistic care. Where family practitioners were combining their individual care skills with comprehensive health care skills, the patient benefited.

Campbell (1995:129) noticed in the RSA, that only a holistic balanced systematic approach could result in an effective, efficient health care service which could meet all the needs of the patient concerned. This was achieved through appropriate referrals to other disciplines, including psychiatry.

Spencer (1995:32) noted that while restructuring the health system in the Western cape, structures for referral systems were maintained (and introduced where necessary) to ensure a smooth effective holistic service. Consultants were appointed to head psychiatric services in general hospitals to provide the necessary consultation services. Bowen (1996:140) elaborated on the restructuring of health care services in the Western Cape and emphasised the need to staff rural health care services with appropriate staff and provide the necessary

support through consultation-liaison with specialists, including psychiatrists.

2.7 FOLLOW ON FROM THE LITERATURE REVIEW

Certain issues were identified during the literature review requiring more in-depth study, to be addressed by this research, namely:

- the appropriateness of referrals to a psychiatric unit in a general hospital in Cape Town
- the extent to which the unit was utilised
- who referred the most/least patients to the unit

2.8 STRENGTHS AND WEAKNESSES OF OTHER STUDIES

The strength of the study described by Creed (1993:204) was the detail of the various diagnoses seen by a psychiatric services in the UK and also comparison between ward and outpatient referrals. This allowed one to see where the referrals were sent from and what type of patients were referred – important information when assessing the needs of the unit such as the need for expansion, future planning and staffing needs.

The limitation of the study was that the data reflected the work of only one of the consultants, thus the other consultants' work was not reviewed. The study could thus reflect on issues such as the consultant's personal reputation and perceived competence by his colleagues which would influence the patients referred to him. The consultant's own special interest and speciality would influence the type and amount of patients referred to him.

Two valuable points were stressed in the study done in the UK described by Jackson (1993:383). Firstly, when a service expanded or was implemented, there was an increase in referrals of patients with minor disorders due to the mere fact of the existence of the unit. This should be anticipated when planning implementation or expansion of psychiatric services. Secondly, there would always be a need for inpatients care despite comprehensive

community resources, due to the "bedrock of illnesses" which prevail, namely the community will never be totally free of psychiatric illnesses no matter how excellent the health care could be. This helps to give a realistic goal when planning services; not to aim at the total absence of admissions to psychiatric hospital but to provide some inpatient facilities as well as outpatient clinics. The weakness of the study was the failure to clearly state the reduction inpatient needs, thus the need for inpatient facilities were not accurately measurable. There would be a reduction in the need for inpatient facilities due to the psychiatric units but the study did not demonstrate exactly by how much the inpatients were reduced. Another drawback of the study was the constant mention that the inception or expansion of a service led to an increase in referrals. This might cause hesitation or failure to begin or expand services because of the extra load that now seemed "unnecessary" or "artificial" because it was generated due to the mere existence of the service, not a genuine need for the patient to be treated by the services (Jackson 1993:382).

The study of Ashley-Smith (1991:7) detailed the positive effects of consultation-liaison psychiatry and the benefits of a psychiatric unit in a general hospital in the Western Cape, thus stimulating others to create similar units. But it is flawed by generalisations and unquantifiable statements such as "most of the referrals cam from medical officers", "they refused to rerouted to specialist psychiatric hospitals". More specific statistics should have supported many of this author's claims.

2.9 FURTHER RESEARCH NEEDED

Further research could complement literature available about referrals received by psychiatric units in general hospitals.

If psychiatric units were providing services perceived by patients and staff as effective, then consumer compliance and utilisation could improve. With the stigma of psychiatry decreasing (Gagiano 1992b:361), it would be important to monitor the difference in patients' compliance to psychiatric treatment provided at general hospitals versus psychiatric hospitals. Provided psychiatric units in general hospitals received appropriate referrals and

provided effective treatment and care, the need for building more and bigger psychiatric hospitals could decline. Thus this research could identify whether a psychiatric unit in a general hospital received appropriate referrals. If this would be found not to be the case, recommendations will be made to improve this situation.

2.10 SUMMARY

The literature review was conducted to gain insight into the available knowledge of referrals received by a psychiatric unit in a general hospital. Both local and international literature was reviewed. The importance of holistic and comprehensive care, and the need for available and accessible psychiatric care made possible through a good consultation-liaison service with good referral systems, were emphasised by many research reports mentioned in chapter 2.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

The data for this study was collected by the researcher by using a checklist that was specifically designed for the study incorporating aspects from the literature reviewed. Data was collected from referral letters received by the psychiatric unit, patient notes and the return letter to the person referring the patient. The checklist was constructed to give structure and consistency to the data collection process and to ensure that quantifiable data was collected (Polit & Hungler 1993:227). A descriptive exploratory design was used because the purpose of the study was to gather new information and statistics, and to attempt to describe their significance (Burns & Grove 1999:192). A quantitative design was used because the study aimed at analysing data pertaining to referrals received by a psychiatric unit in a general hospital in the Western Cape region of the RSA (Burns & Grove 1999:24).

3.2 RELIABILITY

The reliability, namely the stability, consistency, accuracy and dependability of the instrument was tested using an adapted split half test (Bailey 1995:205). This was chosen because the measurement tool could be tested for reliability by assessing whether yielded consistent results on repeated measurements on corresponding parts of the checklist (Waltz 1991:86).

The checklist proved to be reliable when looking at similar questions. In question 29, it was measured that 102 patients were referred elsewhere. In question 31 it was reflected that 71 patients were sent to another psychiatric team member, 17 patients were referred to a social worker, 9 patients were referred to another health discipline and 5 were referred to a specialist psychiatric hospital; totalling 102 patient, exactly the same as revealed in reply to question 29. In question 9 it was reflected that 345 referrals provided sufficient biographical detail, and in question 10 it was reflected 345 times that the information of the missing biographical detail was not applicable, again confirming the previous figure. Similarly in question 13, 346 referrals were sent to the correct person (or unknown), and in question 14, 346 referrals reflected that the reason it was considered that the referral was sent to the incorrect person was inapplicable. Question 15 identified that 341 referrals had sufficient detail of the patients' conditions (or that it was not known if the information was sufficient), and in question 16, 341 referrals indicated that the information missing was not applicable. Similar comparisons with other questions also showed that the checklist could be accepted as providing reliable data.

3.3 VALIDITY

3.3.1 Measures to ensure validity

The accuracy of the checklist to actually test was it is supposed to test, namely the questionnaire's validity, was tested by means of content validity, concurrent validity and face validity (Treece & Treece 1986:119).

3.3.1.1 Content validity

Content validity was tested by submitting the research instrument to five independent validators in the psychiatric field. They were asked to assess the checklist to determine the extent to which factors under study appeared to be measured, thus assessing whether the content of the instrument was appropriate (Treece & Treece 1986:126). The first assessor was a consultant psychiatrist and he judged the checklist to be valid for assessing the quality, nature, effectiveness and appropriateness of referrals and the replies to these. The second assessor was the head of a psychology unit and commented that it appeared to be comprehensive and thorough with no significant weaknesses. The third assessor was a chief professional nurse, head of a psychiatric unit. She assessed that the checklist would measure data pertaining to the referrals received, there did not appear to be any questions that did not contribute to the collection of data regarding the referrals. The fourth assessor, who was a private psychiatrist, commented that it could be useful to include more options on some of the questions to make it less restrictive, and thus measure what it intended to, not what the researcher expected. The final assessor, a professional nurse who worked in a OPD, also stated that the instrument has validity, because all the questions of the checklist pertained to the details of the referrals.

3.3.1.2 Face validity

Face validity, whether the instrument appeared to be measuring what it purported to measure, was found to be present because all questions in the instrument appeared to focus on the selected topic of referrals received by the psychiatric unit in a general hospital (Treece & Treece 1986:130).

3.3.2 Threats to external validity

3.3.2.1 Selection of subjects

All the referrals sent to a psychiatric unit in a general hospital in the Western Cape between

1 January 2000 and 30 June 2000 were used in the study, thus the research population was a convenience group of subjects. Subjects were selected with the study style and purpose in mind to ensure an appropriate population was used (Talbot 1995:214).

3.3.2.2 Setting

The correct setting in which to collect the data is important to eliminate threats to external validity. The study was not done in a laboratory but in the field because the purpose of the study was to analyse a phenomenon occurring in the psychiatric unit (Talbot 1995:214).

3.3.2.3 History

The influence of previous research was not applicable, neither was the issue of a research grant and the resultant responsibilities and expectations (Talbot 1995:214), therefore history posed no threat to the external validity of the study.

3.3.3 Threats to internal validity

3.3.3.1 History

The effect that time could have on a study was negated by doing the study over a limited time (Burns & Grove 1999:190), namely six months.

3.3.3.2 Testing

The outcome of the pretest was not revealed so that the result of the checklist could not contaminate the study results (Talbot 1995:210).

3.3.3.3 Mortality and attrition of subjects

The study was not affected by any mortality. The patients who did not come for their

appointment (n = 65) were included in the study (see question 26 of the checklist) so this also did not adversely affect the study (Talbot 1995:210).

3.4 RESEARCH POPULATION

3.4.1 Selection of the research population group

The research population used in the study were all the referrals received between 1 January 2000 and 30 June 2000 by the psychiatric unit in a certain general hospital in the Western Cape, thus the research population was a convenience group. The entire research population came from one source, namely the psychiatric unit's referrals in a general hospital. The criteria for inclusion in the study was that the patients had to be referred to the psychiatric unit during 1 January 2000 to 30 June 2000, even if the referrals were incomplete or if the patients did not come for their appointments (Burns & Grove 1993:403).

3.4.2 Type of the research population group

The research population was a convenience group because the subjects were accessible and readily available to use and easy to identify (Burns & Grove 1999:234), all subject came from one source, namely the psychiatric unit in a general hospital in the Western Cape. This method of obtaining a research population group was selected because it was anticipated that a sufficient population group would be obtained within the six months to conduct a purposeful exploratory descriptive study.

3.4.3 Size of the research population group

The period of six months was decided on because it was expected to yield approximately 400 referrals. This was thought to be a big enough sample for the purpose of this study. The eventual sample size was 403.

3.5 APPROACH TO THE RESEARCH

3.5.1 Controlling external factors

Extraneous factors/variables are variables that are not the focus of the study (Burns & Grove 1999:94). It was important to eliminate or control external phenomena to ensure the validity of the research instrument (Polit & Hungler 1993:186). This was done by ensuring that the study was done over a limited time of six months to prevent extra variables being introduced over time. All the referrals were evaluated using the checklist guide to ensure that the same approach and criteria were used when collecting data.

3.5.2 Controlling intrinsic factors

3.5.2.1 Randomisation

The group used for the study were all the referrals received by a psychiatric unit in a general hospital in the Western Cape during 1 January 2000 and 30 June 2000. There was therefore no further selection and no control group because the purpose of the study was to gain information in a new field and not to compare any reports directly to previous data.

3.5.2.2 Homogeneity

A further method used in controlling intrinsic factors was that only referrals received by the psychiatric unit during the stipulated time were included in the study (Polit & Hungler 1993:188).

3.5.3 Using records

Records were used to gain information required in the checklist. The main records that were used were the referral letters. Data not found in the referral letters were obtained from other records, such as patient files. Data that was available in the patient files included who

referred the patient, details about the patient, the time between referral and appointment, tests done, other interventions and the feedback given to the referring person.

3.5.3.1 Advantages of the records used

Records were the only source of data used for the study because they were a rich source of data, they were readily accessible, inexpensive and unbiased (because the purpose of the study was not revealed and only documented facts were used). The records were convenient and time saving as opposed to using subjects who often cannot be available when the researcher is. Using records also placed no burden on the patients. The cooperation of patients was not an issue in the study because all the data needed was in the records.

According to Treece and Treece (1986:265), records are more reliable than subjects' memories, thus also more accurate. The availability of extensive amounts of records made data gathering relatively easy and the researcher had a wide choice of material and possibilities for cross referencing. Data was gathered unobtrusively through searching in records as opposed to observation or questioning (Treece & Treece 1986:265), which might alter data. Data gathering using records was also time saving and convenient because the records were kept in a similar manner, thus easy to find (Brondon-Wood 1990:239).

3.5.3.2 Disadvantages of the records used

Information for this study was generally limited in scope to what was available because the subjects were not present, thus if the information was incomplete it was difficult to make it complete (Treece & Treece 1986:265). However, due to the vast amounts of records available to the researcher in this study, information was cross-referenced, namely between the referral letters and the patients' files, even though time-consuming. Another disadvantage of records is that any errors are usually undetected and the data is taken as the true facts (Treece & Treece 1986:265). This was overcome by cross-referencing any dubious data, namely between the referral letter and patient notes. Data from records could be taken out of context (McEvoy 1999:34), this was avoided in the study by cross-referencing data in the

referral with data in the patient notes. Access to records could be very difficult (Treece & Treece 1986:267), but this was overcome by approaching the authorities for permission and building a good relationship with the staff handling the records. Further the researcher investigated the administrative setup and thus learned where the records were kept which made access easier. Handwritten records could be impossible to read, as could unclear carbon copies (Treece & Treece 1986:266). This was overcome by recognising who wrote the referral and asking that person for interpretation (which was very time-consuming) or asking an experienced typist who was used to deciphering handwriting (but misinterpretions could occur).

Data obtained from patients' records was often termed "secondary data" (McEvoy 1999:33) because information has originally been documented for other purposes. But this was turned into an advantage in this study because records were not biassed to fit what the researcher was looking for or expected.

Data from only one psychiatric unit in one general hospital was studied, and this limited the generalisability of information gathered from the records.

3.5.4 Retrospective study

A retrospective study was chosen because the purpose of the study was to investigate a phenomenon that had already occurred (namely the referrals received by a psychiatric unit in a general hospital), and make a statistical analysis.

3.5.4.1 Advantages of using retrospective studies

A retrospective study investigates and reveals a large amount of data about a phenomenon in the past (Polit & Hungler 1993:129). This study revealed data relating to referrals sent to a psychiatric unit in a general hospital. The findings of retrospective studies provide the basis for further research (Brondon-Wood 1990:174). The research led to proposals for further research, such as the recovery and relapse rates of patients using psychiatric units in

general hospitals.

With retrospective studies, data is readily available as opposed to longitudinal studies, where data takes several years to become available (Brondon-Wood 1990:175). The results of this study were available within six months of starting the study.

Retrospective studies tend to be less costly, and the attrition rate is low (Brondon-Wood 1990:175). For this study, the cost was minimal (the printing of the checklist) and the attrition rate was nil because the records were available.

3.5.4.2 Disadvantages of using retrospective studies

In retrospective studies, the researcher has very little control over extraneous variables and thus one cannot draw cause and effect conclusions from the data (Polit & Hungler 1993:128). This was alleviated in this study by incorporating some of the extraneous variables in the study, such as including all age groups and making the groups small. To obtain cause and effect relationships, further studies have been recommended such as the satisfaction of patients with the service received by a psychiatric unit in a general hospital.

Poor objectivity in the collection of data could occur in retrospective studies because researchers tend to look for data they are expecting or wanting (Nieswiadomy 1992:45). This was avoided in this study by setting and strictly adhering to the criteria laid out for the checklist when collecting the data.

3.6 RESEARCH DOCUMENT: THE CHECKLIST

3.6.1 Selection of method of data collection

A new instrument was designed because no applicable instrument was found. A checklist was used as a research tool because it is a simple and rapid method to obtain data and a wide range of information could be gathered (Treece & Treece 1986:228).

3.6.2 Steps adopted while developing and using the checklist

The following steps were adopted in the development and use of the checklist (Polit & Hungler 1993:238):

- determine the information that is to be sought
- literature search
- develop the questions
- determine the sequence of the questions
- subject the checklist to review
- draft the checklist
- do the pretest
- administer the checklist
- score the checklist

3.6.3 Advantages of the checklist

A checklist was used because it is a quick and uncomplicated method of obtaining a broad range of new data (Treece & Treece 1986:228). The checklist took 45 minutes to complete and covered data ranging from the source of the referrals (input), the appropriateness of the referral, the action taken on the referral (throughput) and the result, namely the intervention initiated by the referral (output). A checklist was also used since it was a relatively inexpensive method of obtaining data (the main expense was the printing of the checklist), respondents could remain anonymous (no names were recorded) and closed-ended questions in a checklist were easy to tabulate. A further advantage of a checklist is that it was one of the easiest tools to test for reliability and validity (Polit & Hungler 1993:242). External validity was maintained by using a large sample in order that generalisations might be made to other settings and that the study could be duplicated (Polit & Hungler 1993:195). Research bias (Polit & Hungler 1993:197) was curtailed by setting guidelines to the use of the checklist so that data were collected from a standards base.

3.6.4 Disadvantages of the checklist

A drawback on the checklist was that questions could not be probed – an attempt to overcome this was to construct specific and sufficient questions to collect the necessary data (Treece & Treece 1986:228). Forced choice items were avoided by giving the choice "other" (Polit & Hungler 1993:243) and there were open- and closed-ended questions. The checklist was kept short and no lengthy or ambiguous questions were posed (Bailey 1995:117). There were not double-barrelled or suggestive questions (Polit & Hungler 1993:243) in order to overcome the disadvantage of making the questions too embarrassing or difficult to answer.

The checklists were filled in by the researcher using the guide that was developed to clarity questions and set parameters for measurements. Therefore the potential disadvantage of the checklist where respondents omit certain questions or do not return the checklist was avoided.

The possibility of extraneous variables affecting the study through time (Polit & Hungler 1993:199) was guarded against in that the checklists were completed over a short period (six months) to protect against other variables influencing the study while the study was being done. The effect of being observed (The Hawthorne Effect) (Polit & Hungler 1993:199), was negated by not revealing that the study was being done. Constant measurement errors (Morse 1991:168) were avoided by compiling a checklist guide with appropriate measurement parameters.

3.7 GUIDE TO THE CHECKLIST

QUESTION:

(1) Was the referral source identified?

(2) Was the department from which the patient was referred identified?

(3) State age in years.

(4) State whether the patient was male or female.

(5) State marital status.

(6) State employment status.

(7) State race of patient.

(8) State source of payment for the service received by the patient at the psychiatric unit.

(9) For biographical data to be seen as sufficient there must be at least five of the following:

— Title, for example Mr, Mrs; initial/first name; surname; patient reference number, for example folder number; address; age/date of birth; sex; marital status.

(10) State what information was missing.

(11) The referral was confidential if it came in a sealed envelope or no one beside the referral person and the receiving person could know who the referral pertained to.

(12) An inpatient is one who is admitted to the hospital for whatever reason – an outpatient is one who is not admitted to the hospital.

(13) The referral will be deemed as being sent to the correct person if the receiving person did not refer the patient onto another person and instituted some intervention themselves, for example therapy, medication.

(14) State why the referral was deemed as having been sent to the incorrect person.

(15) Details can be seen as sufficient if three of the following were noted:

— signs and symptoms patient displayed

— onset of signs and symptoms

— duration of signs and symptoms

— present signs and symptoms

— other conditions the patient suffers from

(16) State what information was not given.

(17) Details can be seen as sufficient if three of the following were given (the first must be given):

— treatment that was given

— response to the treatment

— time the treatment was given

— if the patient was still on treatment

(18) State what information was lacking.

(19) State whether the referral was marked urgent.

(20) An urgent request was deemed appropriate if the person receiving the referral made some intervention immediate, for example therapy, medication. If the receiving person gave an appointment to the patient, it was deemed not urgent.

(21) If the receiving person saw the patient immediately or instituted care straight away the referral should have been marked urgent.

(22) State whether the referral requested any specific intervention.

(23) State what the request was.

(24) The intervention that was requested can be seen as appropriate if the person receiving the referral does what was asked in the referral, for example medicate.

(25) State what preventive intervention was requested.

(26) State whether the patient kept an appointment. Even if the patient contacted the unit to cancel the appointment, the patient was seen as having missed the appointment.

(27) State why the patient did not come to the appointment.

(28) State time in days between the referral and the appointment date.

(29) State what intervention was taken by the person receiving the referral.

(30) Indicate all the tests that were done on the patient, if applicable.

(31) State where the patient was transferred to, if applicable.

(32) State the Axis 1 diagnosis of the patient.

(33) State the Axis 2 diagnosis of the patient.

(34) The referring person must specifically request feedback or there must be an allocated space on the referral letter specifically for feedback.

(35) The address must be complete, for example hospital name and department.

(36) Identify if the person receiving the referral gave feedback to the referral source.

(37) Feedback could be seen as adequate if three of the following were mentioned:

— summary of findings

— treatment given

— further plans by the person receiving the referral

— expectations regarding disease process, recovery

— recommendations

(38) State what information was missing.

(39) State if the referral could have been managed more effectively.

(40) What else, if anything, should have been done to manage the referral more effectively?

(41) On the sliding scale, indicate how well the referral was performed.

(42) On the sliding scale, indicate how well the referral was responded to.

3.8 PRETEST

A small scale trial run using the research tool was done between 1 December 1999 to 10 December 1999 to identify any problems with the collection of the data and the use of the checklist. The 21 referrals received by the unit during the ten days of the pretest were used in the pretest.

It was noted in the pretest that referrals received after hours and telephonically or verbally were not included in the study and this could alter the findings of the study. A mechanism to capture those referrals as well was instituted, namely all staff were asked to fill in a form indicating the telephone and verbal referrals they had received so that those referrals could also be included in the study.

After the pretest the checklist was amended because it was noticed that some of the questions did not offer sufficient options, namely options "not applicable" and "unknown" were added to several questions. Other individual choices were also introduced to capture more information. The guide to the checklist was also clarified where ambiguities or problems arose to ensure consistent parameters and measurements when using the checklist. The results of the pretest were kept confidential and the data of the pretest was not used in the main study so that it would not influence the results of the final study.

3.9 SUMMARY

The data was collected using a checklist specifically designed for the study. Reliability and validity of the checklist was evaluated and it was found that the checklist had both reliability and validity. The information was collected over a six month period (1 January 2000 to 30 June 2000) and 403 referrals were evaluated. The research population was a convenience group. A pretest was done on the checklist and subsequently some adaptions were made.

CHAPTER 4

Presentation and discussion of data

4.1 INTRODUCTION

The data was collated and converted into percentages and presented in tables and figures. Data was combined and grouped to make the data more meaningful.

4.2 ANALYSIS OF THE DATA

The data was analysed according to the questions posed earlier in the study.

4.2.1 To what extent was the psychiatric unit being utilised?

During the six months (1 January 2000 to 6 June 2000) 403 patients were referred to the psychiatric unit. Medical officers sent the most patients, namely of the 372 referrals that the source was identifiable, they sent 53,1 percent (n = 197). Specialist (other than psychiatrists)

sent 21,2 percent (n = 79), psychologists sent 11,3 percent (n = 42) and psychiatrists sent 8,0 percent (30). The department that sent the most referrals was the OPD who sent 37,6% (n = 137) of the identifiable 364 referrals. There was a close working relationship between the staff of OPD and the psychiatric unit, resulting in a high referral rate.

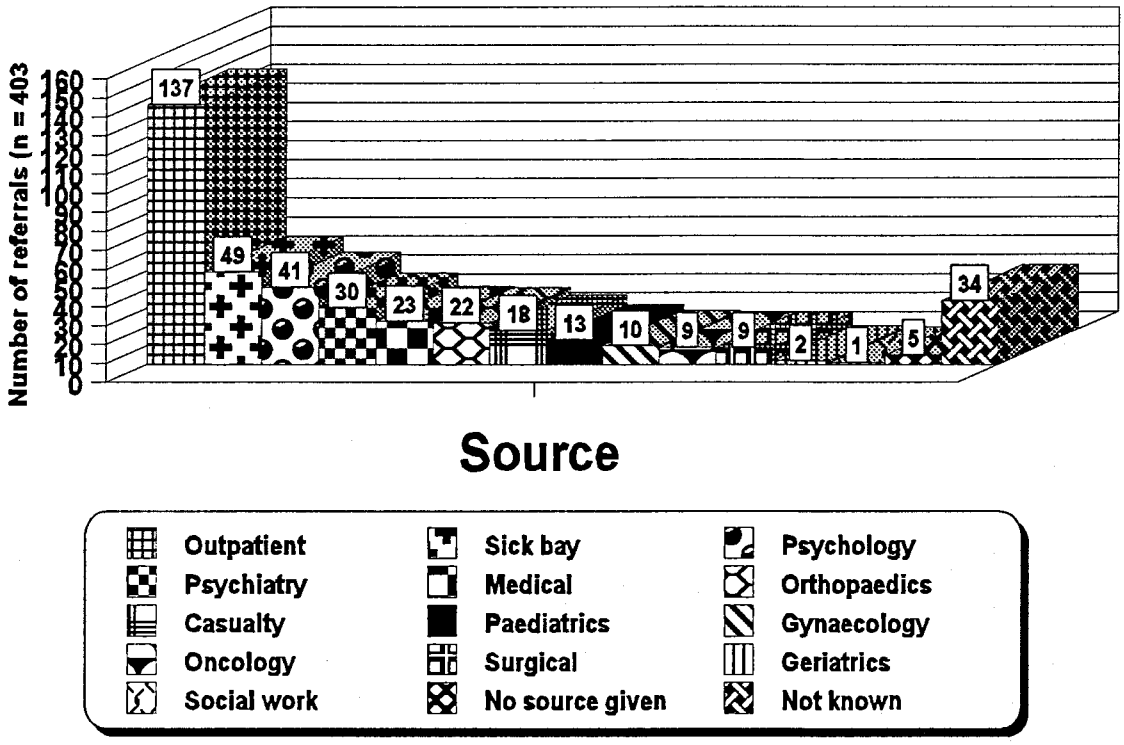

Figure 4.1

Departments referring patients to the psychiatric unit

This was in contrast to what Silverstone (1996:46) reported should occur because he stated that in each of the disciplines cardiology, neurology and respiratory medicine, 25,0 percent of the patients might have accompanying psychiatric illnesses. The results compared with the study done by Dippenaar (1995:27) where referrals from oncology were very low despite the need for cancer patients needing psychiatric care. Dippenaar also noted the poor referral rate of family members for preventive care, despite their difficulties in coping with the patients' conditions.

The largest age group that was referred was the group 31 to 35 year old who constituted 20,1 percent (n = 72) of the 361 identifiable referrals. The smallest number of referrals was

in the age group of 0 to 5 year old, namely 1, 3 (n = 5) percent. According to Oelofse (2000), the largest population the service is provided for is the 25 to 36 year age group, and this correlated with the number of referrals per age group.

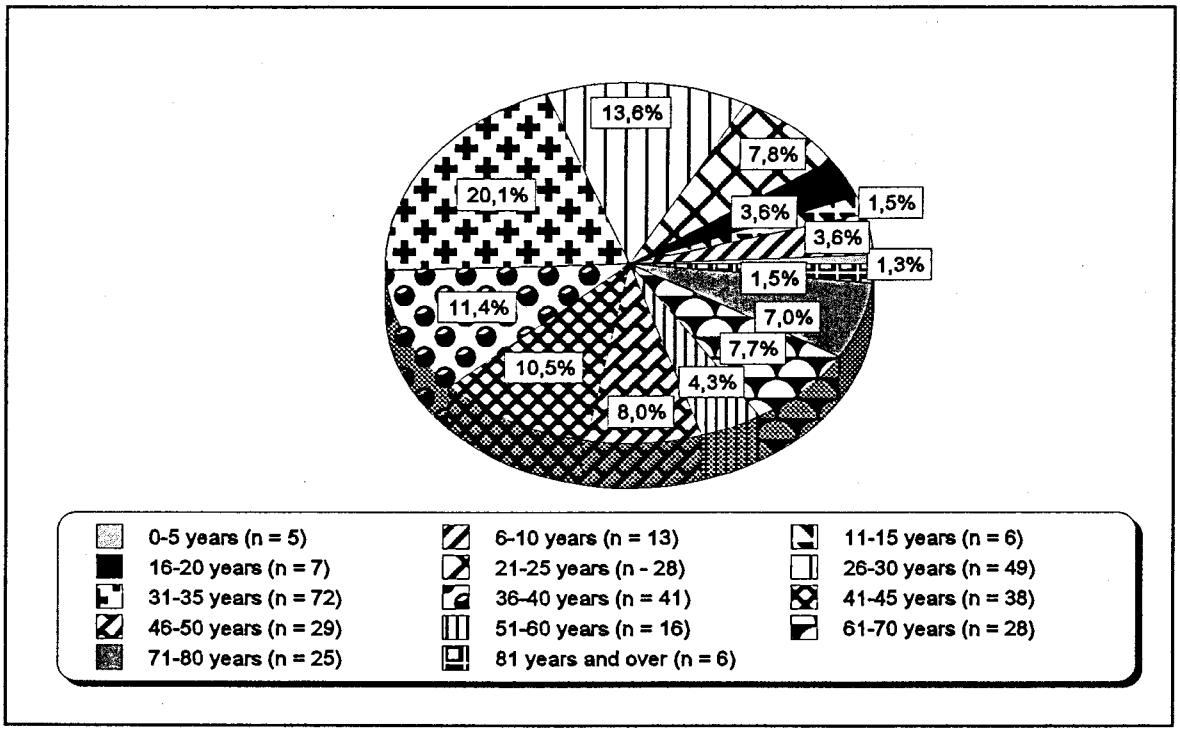

Figure 4.2

Age groups referred to the psychiatric unit (n = 361)

The ages of the referred patients were in contrast to predicted needs identified by other researchers through their studies, but similar to their research findings such as shown in a study done, in the RSA, by Ensink, Robertson, Zissis and Leger (1997:1527), they where found that 40,0 percent of children between 10 and 16 years had a psychiatric illness, yet only 20,0 percent were referred to psychiatry. According to Kramer (1997:508), 38,0 percent of adolescents in the UK had psychiatric illnesses, but only 2,0 percent were referred for treatment. Adolescents in this study comprised only 3,5 (n = 13) percent of the total patients referred.

From the 379 referrals that could be used, 55,4 (n = 210) percent were female and 44,6 percent (n = 169) were male. This is in contrast to Kisely's (1997:538) findings in the UK

where 77,0 percent were female and 23,0 percent were male, also different to Greenfield's (1997:1393) findings in the USA where 69,5 percent of the patients were female and 30,5 percent were male, a ratio in this study of almost 1 : 1 as compared to a ratio of approximately 7 : 3 in the others. The reason for this difference could be attributed to the fact that the study was conducted in a military hospital where the health service services a predominantly male consumer group. However, Farragher's (1998:74) study done in the USA, had similar ratios to this study, namely that 56,0 percent of referrals were females and 44,0 percent were males.

Table 4.1: Referrals according to gender

	MALE		FEMALE		TOTAL	
	n =	%	n =	%	n =	%
This study	210	55,4	169	44,6	379	100,0
Kisley	69	23,0	231	77,0	300	100,0
Greenfield	122	30,5	278	69,5	400	100,0
Farragher	224	56,0	176	44,0	400	100,0
TOTAL	625	42,2	854	57,8	1 479	100,0

The percentage (56,2 percent) (n = 206) of employed patients that were referred was slightly lower than the percentage (62,0 percent) in Greenfield's (1997:1393) study done in the USA, however, the number of unemployed in this study was much higher, namely 24, 1 percent (n = 74) as opposed to 8,2 percent in Greenfield's study.

Of the 355 referrals that could be used, the largest percentage of patients referred were married, namely 60,2 percent (n = 214), while the smallest number were widows/widowers, comprising 6 percent (n = 21). Single patients comprised 20, 5 percent (n = 73) of the referrals and separated and divorces patients comprised 13, 3 percent (n = 47) of the referrals. In Greenfield's study (1997:1393) the composition was different, especially the percentage of separated/divorced patients which was 2,3 percent. Married patients made up 45,5 percent of the referrals, single patients 25,2 percent, and widows/widowers 7,9 percent. Farragher

(1998:74) also found a different composition in her study, namely that 65,0 percent were single, 21,0 percent were married, 7,0 percent were separated, 4,0 percent were divorced and 3,0 percent were widowed.

Table 4.2: Marital status of patients referred

	THIS STUDY		GREENFIELD		FARRAGHER		TOTAL	
	n =	%	n =	%	n =	%	n =	%
Married	214	60,2	227	45,4	63	21,0	504	43,7
Single	73	20,5	126	25,2	195	65,0	394	34,1
Separated	22	6,2	51	10,2	21	7,0	94	8,1
Divorced	25	7,1	561	11,2	12	4,0	93	8,0
Widow/Widower	21	6,0	40	8,0	9	3,0	70	6,1
TOTAL	355	100,0	500	100,0	300	100,0	1 155	100,0

Patients who came as outpatients to the unit comprised 84,2 percent (n = 337) of the 400 useable referrals while 15,8 percent (n = 63) were ward consults. This is lower than the figures shown in Creed's (1993:209) study where 35,0 percent of the referrals were inpatients. Farragher (1998:74) also noted different findings, namely 46,0 percent of referrals were to see inpatients and 54,0 percent were to see outpatients.

In this study 59,4 percent (n = 235) of the 392 usable referrals were for White patients, 22,3 percent (n = 87) were for Coloured patients and 17,7 percent (n = 69) were for African patients. This was not in relation to the demographic make up of the geographical area, but was in relation to the demographic make up of the client base the service was created for, namely the army and navy personnel of the Western Cape. This concurred with the study, also done in Cape Town, done by Strebel (1999:56) where the referrals per race group corresponded with the demographic make up of the area served.

4.2.2 Was the unit being utilised appropriately?

Of the 389 referrals that could be assessed, 82,6 percent (n = 320) were sent to the correct person and 17,4 percent (n = 67) were sent to the incorrect person according to parameters laid out in the guide to the checklist. This is vastly different to the results of a study in the USA where only 0,7 percent of referrals that were made to a forensic psychiatric unit did not have a psychiatric illness and thus only 0,7 percent of patients were sent inappropriately (Van Rensburg 1993:402). Medical officers sent 80,0 percent (n = 152) of their referrals to the correct person, while specialist sent 80,7 percent (n = 63) of their referrals to the correct person.

Table 4.3: Referrals sent to the appropriate person

	SENT TO CORRECT TEAM MEMBER		SENT TO INCORRECT TEAM MEMBER		TOTAL	
	n =	%	n =	%	n =	%
Medical officer	152	40,1	38	9,8	190	49,1
Specialist	63	16,3	15	3,9	78	20,1
Psychologist	36	9,3	4	1,0	40	10,4
Psychiatrist	24	6,2	5	1,3	29	7,5
Other disciplines	45	11,2	5	1,3	50	12,9
TOTAL	320	82,7	67	17,3	387	100,0

When the data regarding the referrals sent to the wrong person was analysed further, it was seen that 46,6 percent (n = 35) were sent to the incorrect team member, 37,3 percent (n = 28) were sent to the incorrect department and 9,3 percent (n = 7) were sent to the psychiatric unit before the patient was medically stable or thoroughly investigated. This may reflect the poor understanding of the referral source in regard to the scope of practice of the various members of the psychiatric team.

Of the 380 assessable referrals, 50,5 percent (n = 192) were sent urgently. Of the 192 referrals sent urgently, 65,1 percent (n = 125) were appropriately referred urgently. Of the 188 referrals sent non-urgently, 19,1 percent (n = 36) should have been sent urgently. This may reflect the poor understanding of what psychiatric conditions needed urgent attention, or that the referral sources were not taking on the task of immediate containment of the patients till they were seen by appointment at the psychiatric unit.

There were seven patients referred tot he psychiatric unit before they were adequately physically screened or treated, thus they were at that time, inappropriately referred, this in keeping with the findings of Kisely (1997:536) who stated that patients were sent to psychiatric units prior to adequate screening or treatment.

Table 4.4: Incorrect urgent and non-urgent referrals

	SHOULD HAVE BEEN SENT URGENTLY BUT WERE NOT		SHOULD NOT HAVE BEEN SENT URGENTLY BUT WERE		TOTAL	
	n =	%	n =	%	n =	%
Medical officer	2	1,9	26	25,2	28	27,1
Specialist	7	6,9	17	16,5	24	23,4
Psychologist	26	25,3	18	17,5	44	42,8
Psychiatrist	1	0,9	6	5,8	7	6,7
TOTAL	36	35,0	67	65,0	103	100,0

Out of the 362 usable referrals, only 1,6 percent (n = 6) requested preventive intervention. This was in keeping with Fawcett's (1993:46) findings but not in keeping with what he recorded should occur, because he indicated that families needed assistance in achieving healthy family functioning and thus did not have optimal health if not referred for preventive or promotive care. It was also not what Harm (1992:326) indicated should occur, who reported that the greater portion of patients should be reached a primary or preventive levels before secondary care was necessary. The low number of requests for preventive treatment might have been due to the referral sources not viewing preventive psychiatric care as a

priority.

From the 400 referrals that were identifiable, 84,2 percent (n = 337) were outpatients and only 15,8 percent (n = 63) were inpatients. Of the 63 inpatients that were referred, 19,3 percent (n = 13) patients were referred for depression.

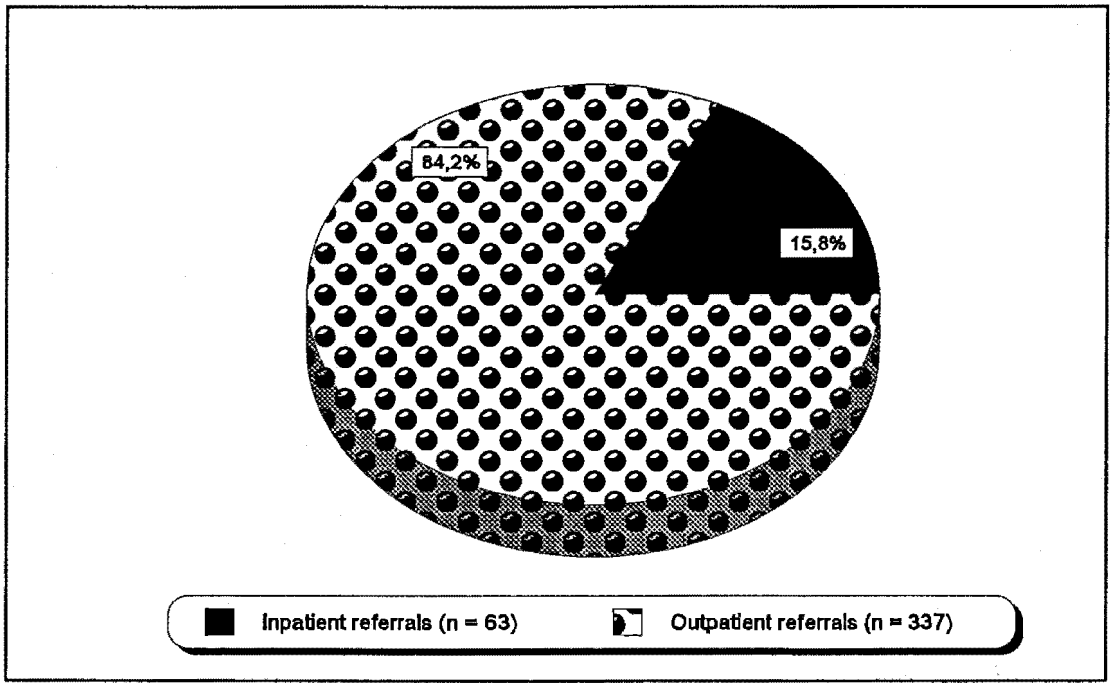

Figure 4.3

Inpatient and outpatient referrals to the psychiatric unit (n = 400)

This was contrary to the needs, but in keeping with expectations of the needs of psychiatric care for inpatients in the USA predicted by Koenig (1998:871) where he indicated that depressed inpatients did not receive sufficient psychiatric care and 45,0 percent of the patients with depression went undetected and untreated. The low rate of referral of inpatients may be due to the general health care team being focused only on the physical aspect of their patients.

4.2.3 Was the unit being utilised effectively?

Of the 339 referrals that stated a request for intervention, 62,8 percent (n = 213) requested

appropriate intervention, thus 37,2 percent (n = 126) of the referrals were ineffective. This showed that the referral sources were not aware of the scope and function of the psychiatric unit.

Table 4.5: Interventions requested in referrals

	APPROPRIATE		INAPPROPRIATE		TOTAL	
	n =	%	n =	%	n =	%
Medical officer	107	31,6	74	21,8	181	53,4
Specialist	41	12,0	25	7,4	66	19,4
Psychologist	32	9,4	10	3,0	42	12,4
Psychiatrist	29	5,6	3	0,9	32	9,5
Other disciplines	4	12,0	14	4,1	18	5,3
TOTAL	213	62,8	126	37,1	339	100,0

This was different to the referrals sent to a forensic psychiatric unit in the RSA where only 48,0 percent of the referrals had psychiatric illnesses and could thus be assessed and treated there (Van Rensburg 1993:402).

There were 3,2 percent (n = 13) referrals which were written illegibly, and thus needed extra energy and motivation to make them effective and usable. Townsend (1993:38) noted the danger of illegible referrals, but made no comment on the frequency with which it occurred.

4.2.4 How soon were the patients seen after referral to the psychiatric unit?

The total days that the 326 identifiable patients had to wait for their appointments were 1 704. The mean (Nieswiadomy 1992:256) was 5,2 days with a range from 0 days (same day) (n = 61) to 67 days (n = 1). The median of the days waited (Hill 1991:64) was 2 days. The mode was 0 days followed by 3 days. This showed that the psychiatric unit had an effective system for seeing patients and that patients did not have long to wait for their appointments. Of the 125 patients that were sent urgently, appropriately 83,2 percent (n = 104) were seen the same

day, and 15,2 percent (n = 19) were seen the next day. This showed that the psychiatric unit had an effective system for seeing urgent referrals the same or the following day.

Table 4.6: Waiting time for appointments at the psychiatric unit

	WAITING TIME
Total days patients waited	1 704 days
Mean days wanted	5,2 days range = 0 to 67 days
Median of days waited	2 days
Mode of days waited	0 days

4.2.5 What was the compliance rate?

Out of the 403 referrals, the compliance rate of the patients who came for their appointment was 83,9 percent (n = 338). this is significantly higher than the study done in the USA by Greenfield (1997:1391) where 56,5 percent of patients arrived for their appointments. Of the patients sent by medical officers, 4,7 percent(n = 19) did not keep their appointments, while 1,5 percent (n = 6) of the patients sent by specialists did not attend. All of the referrals sent by nursing staff (n = 6) and employers (n = 6) arrived for their appointments.

Table 4.7: Compliance rate of patients referred to the psychiatric unit

	COMPLIED		DID NOT COMPLY		TOTAL	
	n =	%	n =	%	n =	%
Medical officer	189	46,9	19	4,7	207	51,6
Specialist	83	20,6	6	1,5	89	22,1
Psychologist	38	9,4	13	3,2	51	12,6
Psychiatrist	19	4,7	17	4,3	37	9,0
Other disciplines	9	2,3	10	2,4	19	4,7
TOTAL	338	83,9	65	16,1	403	100,0

Of the 336 referrals identifiable cases, 97,6 percent (n = 328) were sent confidentially, therefore this was expected to have impacted positively on the compliance rate. Cotroneo, Hopkins, King and Brince (1997:23) noted that the accessibility of psychiatric units played a major factor in compliance rates of patients. The psychiatric unit in this study was very accessible and this contributed to the compliance rate of patients.

4.2.6 What were the diagnoses of patients referred?

Of the 338 referrals where diagnoses were given on Axis 1, 23,1 percent (n = 78) had depression, 18,6 percent (n = 63) had an adjustment disorder and 14,5 percent (n = 49) had an anxiety disorder. No psychiatric diagnoses was found on Axis 1 on 4,1 percent (n = 14) of the referrals. This was slightly different to the findings of Agbayewa (1990:37) in Canada, where 15,0 percent (n = 216) of the patient referred had depression. Ashley-Smith (1991:14) also had slightly different findings in his study in the RSA where adjustment disorder accounted for most referrals, namely 20,7 percent of the case load and depression accounting for 14,8 percent. Mabandla's study in Uys et al (1995:24) done in the RSA also had different findings – having a majority of schizophrenic patients, namely 18,0 percent. These differences might be due to different interpretation of classification of patients' diagnoses by various health care providers (Uys & Middleton 1997:43). The differences might also be due to the variety of consumer groups studied by the researchers, each consumer group being susceptible to different stresses due to their unique strengths and weaknesses (Starkey 1997:11).

Table 4.8: Axis 1 diagnoses of referrals

	THIS STUDY		ASHLEY SMITH		MABANDLA		TOTAL	
	n =	%	n =	%	n =	%	n =	%
Schizophrenia	16	4,7	10	7,4	18	18,0	44	7,6
Bipolar	9	2,7	4	3,0	0	0,0	13	2,2
Depression	78	23,1	20	14,8	13	13,0	111	19,3
Anxiety states	49	14,5	4	3,0	4	13,0	57	9,9
Adjustment disorders	63	18,6	28	20,7	0	0,0	91	15,9
Substance abuse	20	5,9	14	10,4	15	15,0	49	8,5
Other	103	30,5	55	40,7	50	50,0	203	36,3
TOTAL	338	100,0	135	100,0	100,0	100,0	573	100,0

The majority of the referrals had diagnoses of depression, 23,1 percent (n = 78), but only 2,6 percent (n = 9) were in the age groups above 61 years. This is far below the predicted need show in the study done by Clement (1999:375) where he found that up to 45,0 percent of patients older than 60 years of age in France had depression. It was also far below the predicted need shown in Hilton's (1998:66) study where she showed that depression occurred in 50,0 percent of elderly patients.

Of the 372 patients where diagnoses were given on Axis 2, 46,5 percent (n = 173) had no diagnoses, but 18,6 percent (n = 69) had a deferred diagnoses. Antisocial personality was diagnosed on 8,6 percent (n = 32) of the referrals that could be assessed.

4.2.7 Were the referrals adequate?

Of the 30 psychiatrists who initiated referrals, 63,3 percent (n = 19) initiated their referrals excellently or very well, whereas the 42 referrals psychologists initiated 26,1 percent (n = 11) of their referrals excellently or very well. Psychologists initiated 59,5 percent (n = 25) of their referrals poorly and psychiatrists initiated 13,3 percent (n = 4) of their referrals poorly.

Table 4.9: How the referrals were initiated

	EXCELLENT, VERY WELL		SATIS-FACTORILY		POORLY		TOTAL	
	n =	%	n =	%	n =	%	n =	%
Medical officer	87	21,6	66	16,8	45	11,2	198	49,1
Specialist	37	9,2	23	5,7	16	4,0	76	18,9
Psychologist	11	2,7	3	0,8	25	6,2	39	9,7
Psychiatrist	19	4,7	9	2,2	4	1,0	32	7,9
Other disciplines	6	1,5	4	0,9	48	12,1	58	14,4
TOTAL	160	39,7	105	26,2	138	34,1	403	100,0

Of the 355 referrals that information could be gleaned from, 88,7 percent (n = 315) provided sufficient biographical details whilst 11,3 percent (n = 40) gave insufficient biographical details. Out of 355 usable referrals, 92,3 percent (n = 313) gave sufficient details about the patients' conditions. From the 55 referrals that could be used, 80,8 percent (n = 287) gave sufficient details regarding treatment the patients had received prior to referrals. Intervention was requested by 339 (94,1 percent) of the 360 referrals that could be assessed, but only 62,8 percent (n = 213) requested appropriate intervention.

Table 4.10: Inadequate details given in referrals

	BIOGRAPHICAL DETAIL		DETAIL ON PATIENTS' CONDITION		DETAILS ON PATIENTS' TREATMENT		TOTAL	
	n =	%	n =	%	n =	%	n =	%
Medical officer	29	22,3	13	10,0	38	29,3	80	61,6
Specialist	1	0,8	2	1,5	11	8,4	14	10,7
Psychologist	2	1,5	3	2,3	11	8,5	16	12,3
Psychiatrist	2	1,5	0	0,0	5	3,8	7	5,3
Other disciplines	6	4,6	4	3,1	3	2,4	13	10,1
TOTAL	40	30,7	22	16,9	68	52,4	130	100,0

Of the referrals that the medical officers sent, 58,6 percent (n = 247) were inadequate, 18,5 percent (n = 78) of the specialists' were inadequate, 17,7 percent (n = 74) of the psychologists' referrals were inadequate and 5,2 percent (n = 22) psychiatrists' referrals were inadequate.

Table 4.11: Reasons for inadequate referrals

	MEDICAL OFFICER		SPECIALIST		PSYCHOLOGIST		PSYCHIATRIST		TOTAL	
	n =	%	n =	%			n =	%	n =	%
Should have been sent urgently	2	1,1	7	3,7	26	17,8	1	0,5	36	8,5
Should and have been sent urgently	26	13,5	17	8,8	18	9,1	6	3,1	67	16,0
Requested inappropriated intervention	74	28,1	25	7,4	10	3,0	3	0,9	112	26,6
Sent to incorrect team member	38	9,8	15	3,9	4	1,0	5	1,3	62	14,7
Insufficient detail	107	80,0	14	4,0	16	4,5	7	1,9	144	34,2
TOTAL	247	58,6	78	16,5	74	17,7	22	5,2	421	100,0

Of the 96 poor referrals received by the psychiatric unit, 40,6 percent (39) of the referrals were given poor feedback by the psychiatric unit, indicating that a poor referral could engender poor feedback.

4.2.8 What was the process of utilisation of psychiatric care?

The psychiatric unit responded to the referrals by either doing tests (n = 137), giving medication (n = 158), starting therapy (n = 112), admitting the patient (n = 76), sending the patients back to the referral sources with recommendations (n = 24), referrals elsewhere (n = 102) or completing forms for the patients (n = 6).

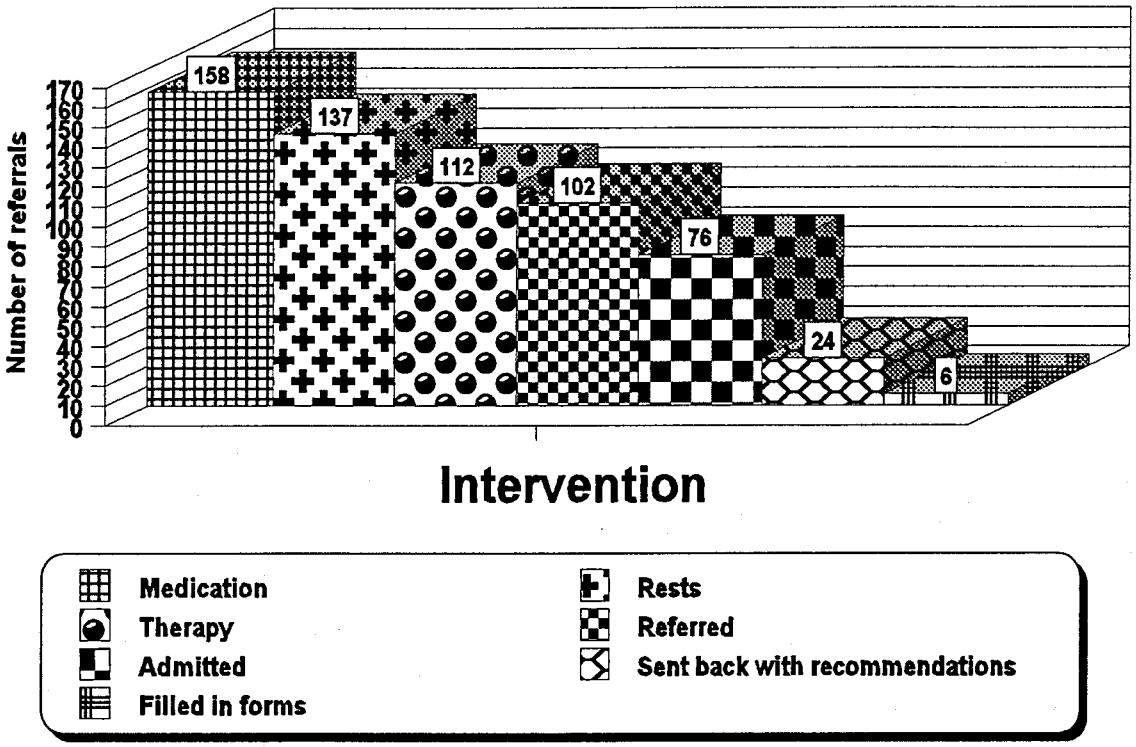

Figure 4.4

Interventions taken by the psychiatric unit

The psychiatric unit usually instituted more than one type of intervention, most frequently therapy and medication in 33,3 percent (n = 118) of patients referred. More than two interventions were instituted in 52,8 percent (n = 187) of patients referred.

None of the patients received neurosurgery. This is in keeping with the practice in the UK as described by Gaze (2000:28) where approximately 30 patients a year have neurosurgery.

4.2.9 How did the psychiatric unit give feedback?

Of the 385 referrals that could be assessed, 38,4 percent (n = 148) referrals did not receive feedback, 21,1 percent (n = 81) received verbal feedback and 37,7 percent (n = 145) received written feedback. Of the feedback that was given, 43,2 percent (n = 137) was given satisfactorily.

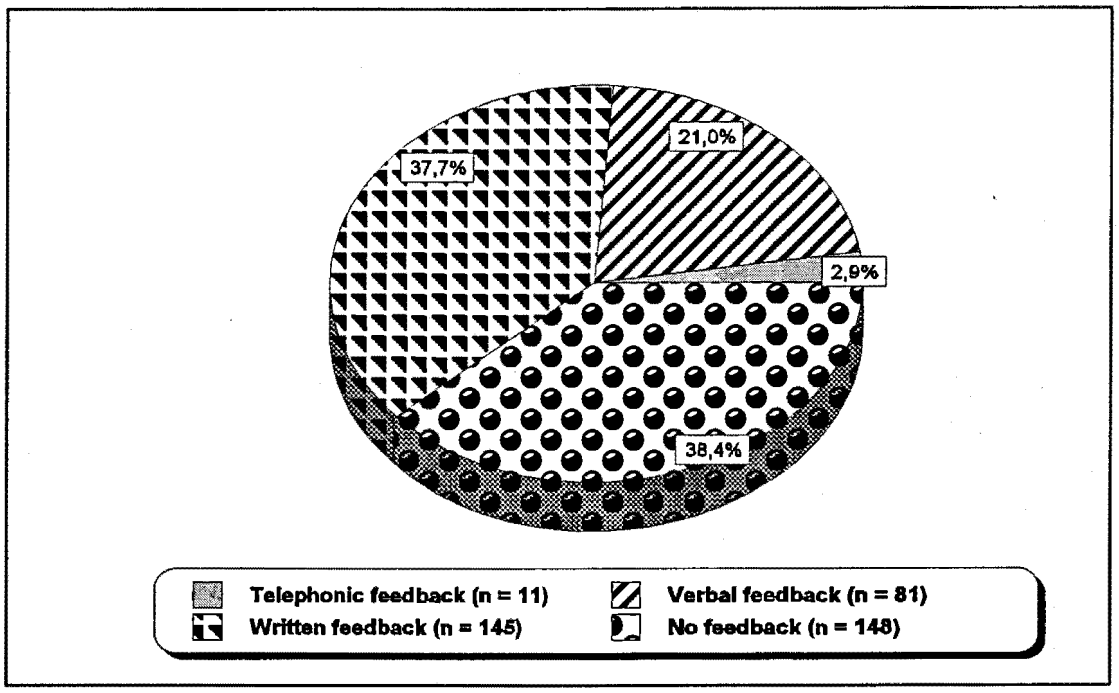

Figure 4.5

Feedback given to referral source by the psychiatric unit (n = 385)

Of the 365 referrals that could be assessed, 93,4 percent had a space for feedback, and 77,3 percent (n = 282) had an address so that feedback could be given. However, only 41,9 percent (n = 143 of the referrals with an allocated space for feedback received written feedback, compared to 37,7 percent in the total study, thus having a specified space for feedback did not have a significant effect on the feedback the psychiatric unit gave. Similarly, having an address to send feedback to did not have an impact on the amount of feedback given to referral sources; of the 282 referrals with addresses, 37,2 percent (n = 105) received written feedback.

4.2.10 Could the referrals have been improved?

Of the 39,7 percent (n = 160) of the referrals received by the psychiatric unit were performed either excellently or very well, while 26,2 percent (n = 105) were performed satisfactorily. The rest, 34,1 percent (n = 138), were performed poorly. Thus the referrals could have been performed more appropriately.

Nurses sent the highest percentage of referrals (100,0 percent) that were either excellent or done very well, however, they only referred six patients. The feedback given by the psychiatric unit could also have been improved in that 38,4 percent (n = 148) of the referrals did not receive feedback and 21,0 percent (n = 81) only received verbal feedback.

The one aspect of consultation (Harber 1998:68) by the psychiatric unit was fulfilled in that all the patients referred to the unit were seen, and seen promptly, but the aspect of feedback was not performed well.

4.3 SUMMARY

During the six months of the study, 403 referrals were received by the psychiatric unit. Medical officers sent the most referrals, namely 53,1 percent (n = 197) and the outpatients department was the department which sent the most referrals, 37,6 percent (n = 137). The most frequent age group that was referred was the age group 31 to 35 years, 20,1 percent (n = 72). The distribution of females and males referred was 55,4 percent : 44,6 percent and 60,2 percent (n = 214) of the patients referred were married. Inpatients accounted for 15,8 percent (n = 63) of referrals and 97,6 percent (n = 328) of the referrals were kept confidential. The most common diagnosis was depression, namely 23,1 percent (n = 78) of referrals.

The compliance rate was 88,0 percent (n = 356) and the average time between referral and appointment was 5,2 days with 62,3 (44,9 percent) being seen the same day. The most common response to the referrals was giving medication 46,7 percent (n = 158).

Only 39,7 percent (n = 160) of the referrals were initiated excellently or very well, and 34,1 percent (n = 138) were performed poorly. No feedback was given tot he primary source in 38,4 percent (n = 148) of the referrals and written feedback was only given in 37,7 percent (n = 145).

CHAPTER 5

Research report

5.1 INTRODUCTION

At the outset of the study, it was anticipated by the researcher that there would be recommendations regarding the improvement of referrals by health providers to the psychiatric unit. Since doing the research, it was noticed that there could also be an improvement in the quality and quantity of the feedback that the psychiatric unit provided to the referring department/professional person.

5.2 CONCLUSIONS

5.2.1 To what extent was the psychiatric unit in a general hospital being utilised?

The research was done at a military hospital and therefore some of the findings differed from that of other psychiatric units, such as a higher ratio of males to females (1:1 as opposed to

7:3 in the study done by Greenfield (1997:1393) , and fewer geriatric patients. The source of payment also differed from other studies because the employer provided full medical care as part of the employment contract. Inpatient referrals were low especially from the Departments of Gastroenterology (n = 0), Oncology 2,5 percent (n = 9), Geriatrics 0,5 percent (n = 2) and Internal Medicine 6,3 percent (n = 23). This was in keeping with findings in the study done in the USA by Silverstone (1996:46) where he stated that 25,0 percent of the patients from these departments had accompanying psychiatric illnesses, but very few were referred to psychiatry. There was a good referral rate from the Orthopaedic Department 6,0 percent (n = 22), considering that there were more than half the number of orthopaedic patients.

5.2.2 Was the psychiatric unit being utilised effectively?

Very few patients were referred for preventive interventions (n = 6). This might indicate that health care staff accorded low priority to preventive care and thus did not readily refer patients for preventive or promotive mental health. This is in keeping with what Strong (2000:24) found in her study in the UK. This could be overcome through educating personnel and impressing on them the need for preventive and promotive psychiatric health care. The high percentage of referrals with inadequate details, 36,6 percent (n = 130) referrals being sent to the incorrect team members, 17,3 percent (n = 67) and referrals with inappropriate requests for intervention, 37,2 percent (n = 126) showed that the referral sources had a poor concept of what information the psychiatric unit required or what the scope and function of the unit entailed.

5.2.3 Was the psychiatric unit being used appropriately?

Of the 368 referrals that were identifiable 83,2 percent (n = 306) were sent to the correct person, thus appropriate. Of the 192 referrals that were sent urgently 65,1 percent (n = 125) were sent appropriately urgent. Of the 188 referrals sent non-urgent 80,9 percent (n = 152) were sent appropriately non-urgently. There was no data collected on the appropriate timing of the referrals, namely whether they were prompt or delayed inappropriately. The

psychiatric unit therefore appeared to be used appropriately in the majority of referrals.

5.2.4 Were the referrals adequate?

Psychiatrists initiated 63,3 percent (n = 19) of their referrals adequately, while psychologists initiated 26,1 percent (n = 11) of their referrals adequately. Psychologists in particular need to have in-service education to improve their referrals. It is disconcerting that psychologists refer to staff in their own team and in their own field so poorly. Specialists referred 46,8 percent (n = 38) of their referrals adequately, and medical officers 44,6 percent (n = 88). This is also poor, and again in-service education is indicated because it appears that they do not know the details the psychiatric unit needs in a referral.

5.2.5 What was the compliance rate?

Data showed that not all patients kept their appointments, but insufficient information was gathered during this research to provide reasons. The compliance rate was higher than in the study done by Greenfield (1997:1395) in the USA, where 56,6 percent of patients arrived for their appointment. The good response rate in this study could be attributed to the fact that if patients failed to keep their appointments, it might be known by their superiors. In this study, all patients who were referred by their employers to the psychiatric unit, did keep their appointments. Another reason for the high compliance rate was that the patients did not have to pay for their treatment because medical cover was part of their employment contract. This was in keeping with Mohr's (1995:215) findings in the USA where patient compliance increased when payment for services was not required.

5.2.6 How soon were the patients seen after referral to the psychiatric unit?

The short time between referral dates and appointment dates (mean waiting time was 5,2 days) indicated that there was an effective system for accepting and seeing patients. The high percentage of patients seen on the same day as the referrals (44,9 percent; n = 62) indicated that the system for seeing patients who required urgent attention, functioned

effectively. patients were referred to outlying specialist hospitals.

5.2.7 What were the diagnoses of the patients referred?

The most referrals were for depression (23,1 percent; n = 78) but did not reflect the amount of predicted depressed patients in the 60 and over age group predicted by Hilton (1998:66). This group needs to be targeted, referred and treated.

5.2.8 What was the process of utilisation of psychiatric care?

The psychiatric unit performed a wide range of interventions, thus it appears their treatment was thorough. Tests were done on 38,7 percent (n = 137) of the patients, this showed a high level of screening. Many patients (52,8 percent; n = 187) had more than two types of intervention, thus it appeared that the psychiatric unit used a multifaceted approach to treatment. Only 5 (1,2 percent) patients were referred to a specialist psychiatric hospital, thus allowing almost all (98,8 percent; n = 333) patients to be treated near their homes. This was in contrast to Ashley-Smith's (1991:11) study also done in the RSA where 38,0 percent of psychiatric patients were referred to outlying specialist hospitals.

5.2.9 How did the psychiatric unit give feedback?

The poor rate of feedback which the psychiatric unit gave to the referral sources (38,6 percent of referrals did not receive feedback) might be indicative of the poor communication amongst the health staff. The reason for the communication being inadequate was not investigated in this research. The skills of the referral sources were not improved due to the lack of feedback from the psychiatric unit. The consultation function of the psychiatric team was thus not fulfilled in that inadequate feedback was given to the referral source.

5.2.10 Could the referrals have been improved?

Both the initiation and the response to the referrals could have been improved in that

24,8 percent (n = 96) of the referrals were sent poorly, and 56,8 percent (n = 198) were responded to poorly (no written feedback). The emphasis and effort for improvement of referrals must therefore be placed on improving the quality and quantity of feedback given by the psychiatric unit. The feedback must be more detailed and must be given in writing. Even when referrals had a space for feedback and an address was given, the psychiatric unit did not improve their feedback.

5.3 RECOMMENDATIONS FOR IMPROVEMENT OF REFERRALS

To improve the quality of the referrals, such as sending the referral to the correct person and supplying sufficient detail, health staff need to be educated regarding the scope of the psychiatric unit. This can be done as part of in-service education or during the various courses health staff undergo in their training. This was echoed by Radcliffe (2000:21) where he records that staff often do not know the skills and functions of the psychiatric units.

Inpatient referrals need to increase to reach expected levels and to ensure appropriate care of all inpatients. To improve inpatient referrals, health staff need to be given in-service education regarding the signs and symptoms of psychiatric illnesses and the necessity for referral to a psychiatric unit to ensure holistic care. Certain departments should be especially targeted such as gastroenterology, neurology, oncology and internal medicine. The fact that elderly patients are especially prone to more than one illness, and their susceptibility to depression should be impressed to health staff to ensure that more elderly patients are referred. Health staff should be educated regarding the signs and symptoms of depression in the elderly so that they can identify and refer appropriate patients to the psychiatric unit.

To increase the number of referrals requesting preventive intervention, health staff need to be educated about the scope and functions of the psychiatric unit and what it offers regarding preventive care. This can be done at Mental Health Day and other outreach programmes where the public could also be informed about the activities of the psychiatric unit and where to seek further information. To further increase the number of referrals requesting preventive interventions, the psychiatric unit should market itself and make itself known as a dynamic

unit providing comprehensive care including preventive and promotive mental health services.

Feedback to the primary source is very important and must be instilled in all the team members of the psychiatric unit. An increased feeling of responsibility regarding good communication and the acceptance of the necessity of good communication must be instilled to improve feedback. The psychiatric team need to be educated regarding the importance of adequate written feedback. Appropriate feedback is important to ensure continuity of effective care and to prevent medico legal hazards due to poor documentation. This could be done through good role modelling by senior personnel and teaching during training and in in-service education programmes.

5.4 RECOMMENDATIONS FOR FURTHER STUDIES

The reason there was different statistics regarding the diagnoses of referrals should be investigated by studying whether the health team members were using the DSM 4 R correctly and how much did culture and race play in mental illnesses and referrals.

The satisfaction of consumers of the psychiatric unit in a general hospital should be studied to assess what the perceptions and needs of the consumers were, and to ensure that service was geared to fulfill these if appropriate. The satisfaction of other health staff on the psychiatric unit should also be investigated to ensure their needs are met and thus referrals should increase and patients care should improve.

The relapse and recovery rates of consumers of psychiatric units in general hospitals should be studied to determine whether the patients attending psychiatric units relapse less often and have quicker recovery rates than the patients who are not referred.

The reason why some of the patients did not come for their appointments should be investigated to improve compliance. With the stigma of psychiatry becoming less, it could be valuable to keep updated as to what keeps some patients from attending psychiatric units.

Is the reason for non-compliance because there is poor motivation of patients by the health staff, the remaining stigma surrounding psychiatry, mistrust of the psychiatric unit by health staff and patients or the poor accessibility of the unit? Research could not be traced which provided answers to these questions.

The poor communication including poor feedback to the primary source, should be investigated. Is it due to time constraints, professional jealousy and secrecy or the poor insight into the importance of feedback?

The small number of referrals from inpatients needs to be investigated. Was the reason professional jealousy and pride, poor insight into the signs and symptoms of psychiatric illnesses or lack of trust and faith in the psychiatric unit?

The impact of psychiatric training (received by all student nurses) on the treatment patients receive in the general hospital should be investigated to assess the future needs for patients to be referred to psychiatric units.

The study of referrals received by psychiatric units in general hospitals should be studied in more hospitals to obtain more generalisable data. The time span of the study should also be increased and the study should also not be limited to a military hospital, this would further assist in the generalisability of the study.

The study should also include observations (to assess what happened prior and subsequently to referrals) and questionnaires (to gain more data). This would enable more detailed and comprehensive information to be gathered.

5.5 SUMMARY

Health staff need to be given in-service education regarding the function of psychiatric units including that it provides preventive health care. Health staff also need to be educated regarding the signs and symptoms of psychiatric illnesses so that they can easily identify

psychiatric illnesses and refer promptly.

It is recommended that further research be done to investigate the current reason for patients not keeping their appointments. As current priorities and tenets change, it is important to keep up to date with current trends and adapt to continuously provide an appropriate and effective psychiatric health service.

Despite the limitations of the study, meaningful conclusions could be reached because of the research findings and recommendations given. The recommendations could be used by the hospital to improve their consultation – liaison network and foster holistic care. Other hospitals, with appropriate adaptions, could adopt the recommendations to improve their service.

> *A system is a set of units so related or connected as to form a unity or whole and characterized by inputs, outputs, and control and feedback processes.*
>
> *Roy (in Marriner-Tomey 1994:248).*

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Annexure A

Permission to a study on referrals received by ward 11

2MH/R/87765632CA

Telephone: 469 2911
Extension: 2274
Enquiries: Sr M. Dor

2 Military Hospital
Private Bag X4
Wynberg
7824

March 2000

The Officer Commanding
2 Military Hospital
Private Bag X4
Wynberg
7824

Colonel

PERMISSION TO A STUDY ON REFERRALS RECEIVED BY WARD 11

1. Please could you consider the following request.

2. I am studying for my M.Cur through UNISA and as part of my course I need to do a research study. The study will be evaluating the referrals received by a psychiatric unit in a general hospital. What will be assessed will be which department referred the patient and which patients are referred.

3. Could I ask permission to do this study on Ward 11 during the year 2000.

4. I ensure it will be done in my own time.

5. Thank you

(M. DOR)
SENIOR PROFESSIONAL NURSE: SR

MD/CB

RECOMMENDATION/REMARKS BY AREA MANAGER:

Not applicable

AREA MANAGER: ASSISTANT DIRECTOR DATE

RECOMMENDATION/REMARKS HEAD OF DEPARTMENT

Permission granted

CHIEF OF PATIENT CARE: ASSISTANT DIRECTOR: LT COL 17/3/00 DATE

REMARKS/RECOMMENDATION BY OFFICER COMMANDING:

Approved

OFFICER COMMANDING 2 MILITARY HOSPITAL: COL 22/3/00 DATE

Annexure B

Checklist

Checklist on Referrals

Kindly respond to the following questions by marking (X) over the appropriate number or writing the required information in the open space.

		FOR OFFICE USE ONLY
	Patient number	☐☐☐ 1-3
1	**Who referred the patient?** Medical officer = 1 Specialist = 2 Nursing staff = 3 Social worker = 4 Family = 5 Teacher = 6 Old age home = 7 Employer = 8 Religious leader = 9 Community member = 10 Police = 11 No source identified = 12 Psychologist = 13 Psychiatrist = 14 Self = 15 Unknown = 16 Other = 17 (please specify)	☐☐ 4-5
2	**Which department referred the patient?** Casualty = 1 Sick bay = 2 Outpatients = 3 Surgical department = 4 Medical department = 5 Paediatrics = 6 Geriatrics = 7 Orthopaedics = 8 Oncology = 9 Psychiatry = 10 Psychology = 11 Social work = 12 Court = 13 No source supplied = 14 Gynaecologist = 15 Not known = 16 Other = 17 (please specify)	☐☐ 6-7

				FOR OFFICE USE ONLY
Patients' biographical data				
3	**Age**			
	0 - 5 years	=	1	
	6 - 10 years	=	2	
	11 - 15 years	=	3	
	16 - 20 years	=	4	
	21 - 25 years	=	5	
	26 - 30 years	=	6	
	31 - 35 years	=	7	
	36 - 40 years	=	8	
	41 - 45 years	=	9	
	46 - 50 years	=	10	
	51 - 60 years	=	11	
	61 - 70 years	=	12	
	71 - 80 years	=	13	
	81 years and over	=	14	
	Unknown	=	15	☐☐ 8-9
4	**Sex**			
	Female	=	1	
	Male	=	2	
	Unknown	=	3	☐ 10
5	**Marital status**			
	Single	=	1	
	Married	=	2	
	Separated	=	3	
	Divorced	=	4	
	Widow/widower	=	5	
	Not known	=	6	☐ 11
6	**Employment status**			
	Scholar	=	1	
	Employed	=	2	
	Unemployed	=	3	
	Retired	=	4	
	Boarded	=	5	
	Unknown	=	6	☐ 12
7	**Race**			
	White	=	1	
	African	=	2	
	Coloured	=	3	
	Indian	=	4	
	Unknown	=	5	☐ 13

		FOR OFFICE USE ONLY
8	**Source of payment** Medical aid = 1 State = 2 Family = 3 Friends = 4 Employer = 5 Self = 6 Combination = 7 Unknown = 8	☐ 14
9	**Was there sufficient biographical data?** Yes = 1 No = 2 Unsure = 3 Unknown = 4	☐ 15
10	**If not, what information was missing?** Not applicable = 1 Title = 2 Initial/First name = 3 Surname = 4 Patients' reference number = 5 Patients address = 6 Age or date of birth = 7 Sex = 8 Marital status = 9 Race = 10 Unsure = 11	☐☐ 16-17
11	**Was the patient's identity and information kept confidential?** Yes = 1 No = 2 Unknown = 3	☐ 18
12	**Patient's status** Inpatient = 1 Outpatient = 2 Unknown = 3	☐ 19
13	**Was the referral sent to the correct person?** Yes = 1 No = 2 Unknown = 3	☐ 20

		FOR OFFICE USE ONLY
14	**If not, why was it considered incorrect?** Not applicable = 1 Incorrect department = 2 Incorrect team member = 3 Needed physical treatment before psychiatric treatment could begin = 4 Another psychiatric facility nearer patient's home = 5 Medical aid restrictions = 6 Other = 7 (please specify)	☐ 21
15	**Did the referral state sufficient details regarding the patient's condition?** Yes = 1 No = 2 Unsure = 3	☐ 22
16	**If no, what information was not given?** Not applicable = 1 Signs and symptoms patient displayed = 2 Onset of signs and symptoms = 3 Duration of signs and symptoms = 4 Present signs and symptoms = 5 Other conditions the patient suffers from = 6 Illegible = 7 Other = 8 (please specify)	☐ 23
17	**Was there sufficient detail regarding treatment the patient has already received?** Yes = 1 No = 2 Unsure = 3 Not applicable = 4	☐ 24
18	**If no, state what was lacking?** Not applicable = 1 Treatment that was given = 2 Who gave the treatment = 3 Response to the treatment = 4 Length of time the treatment was given = 5 Unreadable = 6 Other = 7 (please specify)	☐ 25
19	**Did the referral request urgent attention?** Yes = 1 No = 2 Not known = 3	☐ 26

		FOR OFFICE USE ONLY
20	**If yes, was this appropriate?** Not applicable = 1 Yes = 2 No = 3	☐ 27
21	**If no, should it have been urgent?** Not applicable = 1 Yes = 2 No = 3	☐ 28
22	**Did the referral state what intervention was requested?** Yes = 1 No = 2 Not known = 3	☐ 29
23	**If yes, what was the request?** Not applicable = 1 Take over management = 2 Treat = 3 Give an opinion = 4 Assess = 5 Consult = 6 Medicate = 7 Counsel/therapy = 8 Admit = 9 Help = 10 Evaluate = 11 Fill in forms = 12 See patient = 13 Other = 14 (please specify)	☐☐ 30-31
24	**Was the intervention requested appropriate?** Not applicable = 1 Yes = 2 No = 3	☐ 32
25	**What preventive intervention was requested?** None = 1 Health education = 2 Screening of a well or at risk patient = 3 Prevention of deterioration of a medical condition = 4 Marriage counselling = 5 Family therapy (as opposed to only treating the index patient) = 6 Not known = 7	☐ 33

		FOR OFFICE USE ONLY
26	**Did the patient come for his/her appointment?** Yes = 1 No = 2	☐ 34
27	**If not, give the reason.** Not applicable = 1 Unknown = 2 Needed further motivation = 3 Patient refused treatment = 4 Other = 5 (please specify)	☐ 35
28	**What was the time between the date of the referral and the date of the appointment at the psychiatric unit?**	☐☐ 36-37
29	**What intervention was taken?** Not applicable = 1 Referred back with recommendations = 2 Tests were done = 3 Medication was given = 4 Therapy was begun = 5 Patient was admitted = 6 Patient was referred elsewhere = 7 Forms were completed = 8 Unknown = 9	☐ 38
30	**If tests were done, what was done?** Not applicable = 1 Blood tests = 2 X-rays = 3 CT scan = 4 Psychometric tests = 5 Psychoneurological testing = 6 EEG = 7 Mini mental = 8 Other = 9 (please specify)	☐ 39
31	**If the patient was referred elsewhere, state where.** Not applicable = 1 Another psychiatric team member = 2 Social worker = 3 Specialist psychiatric hospital/service = 4 Other = 5 (please specify)	☐ 40

		FOR OFFICE USE ONLY
32	**What was the Axis 1 diagnosis?**	☐☐☐☐☐ 41-45
33	**What was the Axis 2 diagnosis?**	☐☐☐☐☐ 46-50
34	**Was there a request or a space on the referral form to give feedback to the person referring the patient?** Yes = 1 No = 2 Not applicable = 3 Not known = 4	☐ 51
35	**Was there an address on the form so that feedback could be given?** Yes = 1 No = 2 Not applicable = 3	☐ 52
36	**Did the person receiving the referral give feedback to the source?** No = 1 Telephonically = 2 Verbally = 3 Written = 4 Unsure = 5	☐ 53
37	**Was the feedback adequate?** Not applicable = 1 Yes = 2 No = 3 Not known = 4	☐ 54
38	**If not, what information was missing?** Not applicable = 1 Unsure = 2 Summary of findings = 3 Treatment given = 4 Further plans by the person receiving the referral = 5 Expectations regarding disease process recovery = 6 Recommendations = 7 Illegible writing = 8	☐ 55
39	**Could this referral have been managed more effectively?** Yes = 1 No = 2	☐ 56

		FOR OFFICE USE ONLY
40	**If yes, give explanation.** No applicable = 1 More detail needed = 2 Send to correct team member = 3 Should have been sent urgent = 4 Better feedback = 5 Written feedback = 6 Illegible writing = 7 Patient motivation = 8 Should not have been sent urgent = 9	☐ 57
41	**How was the referral performed?** Excellently = 1 Very well = 2 Satisfactorily = 3 Poorly = 4 Unusable as is = 5	☐ 58
42	**How was the referral responded to?** Excellently = 1 Very well = 2 Satisfactorily = 3 Poorly = 4 Of no benefit to the referral source = 5 Not applicable = 6	☐ 59

Thank you for completing the checklist!