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Psychiatric Referrals: Protocols and Courtesies of Referral to Hospital

by
B. White [2]

The core aim of the psychiatric referral is to arrange for the most appropriate treatment and management for a patient. Such management should be both appropriate for the patient and the problem and should use available resources wisely. The more information relating to the problem, and the more accurate the information, the better.

Introduction

Hospital referrals should initially by phone call and should be backed up by written letter. The referring doctor needs to provide a succinct but accurate history and formulation, perhaps a brief version of that expected in psychiatry exams, especially if a registrar in psychiatry or a psychiatrist refers the patient. It should include pertinent medical history; history of prescribed medications (many patients do not know the names and dosages of medication they take), over the counter medication, caffeine, alcohol and illicit drug use; recent investigations and medical reports. The psychiatrist accepting the admission will try to prepare an effective and appropriate management plan. Which benefits the patient, uses resources prudently, and does not make the condition worse. As there are adverse effects from hospital admission, including fostering dependence and atrophy of daily coping skills, admission to hospital is not always appropriate.

The treating psychiatrist will focus on what is the real problem at the time. If the patient has issues not revealed by the referral appropriate management may be delayed and admission may even be declined. If the real problem is not a significant psychiatric issue warranting hospital admission, this should be discussed by phone. This may avoid further inappropriate assessment. Admission and inpatient management is an active process. Although 'time out' can be part of this, a more active therapeutic process is expected, both on professional grounds and by the insurance companies.

The Referral

A referral should elucidate the issue of why "this person" is "here" and "why now". While a patient may have a psychiatric illness, such as chronic schizophrenia, the current problem may be an adjustment reaction to a domestic crisis. Appropriate referral is designed to streamline assessment, admission (or not) and treatment. It is a waste of both the consultant and the patient's time to be seen and then told that this is neither the appropriate specialist nor specialty.

The initial referral should inform why this person is here now. Admission is primarily indicated for psychiatric illness. In some cases, the psychiatric process may be secondary to a physical condition, which needs treatment. If management is reliant on the treatment of the physical condition, admission to a medical unit is probably more appropriate. The problem also needs to be significantly acute. If inpatient admission of a patient with chronic problems is sought, then extensive background information is critical to allow careful consideration of the pros and cons of admission and ongoing hospital management.

A referral should be accurate and not misleading, whether from inadequate assessment or deliberate obfuscation. I would not expect a consultant physician or surgeon to see a patient whose referral simply indicates, for example, abdominal pain or chest pain without a thorough history and examination. Some acute referrals to

the psychiatry units, however, have been of such brevity and apparent lack of assessment by the referee as to be meaningless. Assessments from a psychiatric registrar or psychiatrists are rightfully subject to an increased expectation that the assessment formulation and management proposed is more thorough and thoughtful.

Terms such as "major depressive episode", used when the case is clearly that of a patient with a borderline personality disorder, are misleading. Describing a patient as feeling acutely suicidal'. when there is very chronic depression and chronic suicidal thinking, is also misleading. Referrals, which only use statements such as "feels unsafe" or "is suicidal", are almost meaningless. Suicidal thinking is a complex process that has multiple levels of severity and dangerousness. There are many people who have chronic thoughts of suicide as part of their chronic condition and this is probably as much a habit of thinking as any other process. Therefore, such simple statements as "feels unsafe" without clear elaboration are insufficient.

Deliberate obfuscation only serves to irritate the psychiatrist and delay appropriate therapeutic management. Whilst a misleading referral may succeed at times in getting a problem patient out of the referee's hands, the resultant lack of trust in the referee's clinical knowledge and skills by the psychiatrist may be detrimental in the long term.

Professional Requirements

Technically, a written referral addressed personally to the consultant taking on the management of the case is required. This should include a provider number. While the psychiatrist can admit a patient without referral and bill them directly, they have no recourse to rebate from Medicare, Veteran's Affairs or medical insurance without an appropriate medical referral. Patients with private insurance should ensure that the insurance adequately covers their admission to hospital or, if not fully covered, that they are able to manage these costs. Patients will receive a separate account from the treating psychiatrists. As many patients referred to psychiatric units have had some degree of crisis and stress, their condition will not be helped if they find themselves in debt due to either a significant gap payment or lack of eligibility for private health insurance for a particular condition. The referring doctor needs to be aware of this. Having private health insurance is not a de facto reason for admission to a private hospital. Admission is made on the basis of clinical need and not on a patient's desire to be in a place of comfort. Finally, the admitting psychiatrist is the only one who can make or delegate the decision to accept a patient for admission. The admitting psychiatrist takes responsibility for the management of a patient, not the referring doctor.