

PSYCHIATRIC REFERRALS IN CONSULTATION-LIAISON PSYCHIATRY: SOCIOCULTURAL AND CLINICAL INSIGHTS FROM A TERTIARY CARE HOSPITAL

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Abstract

Background: Psychiatric referrals are critical for the management of patients presenting with mental health issues in a clinical setting. Understanding the socio-demographic characteristics, referral patterns, reasons for referral, and the psychiatric diagnoses associated with these referrals is essential for improving mental health care in India. This study aims to evaluate the factors influencing psychiatric referrals in a tertiary care hospital and assess the common psychiatric conditions observed in the referred population. **Materials and Methods:** A prospective, cross-sectional study was conducted at a tertiary care hospital, analyzing psychiatric referrals over a period of one year. A total of 200 patients referred to the psychiatry department were included. Data were collected systematically from patient referred for consultation liaison services and categorized by gender, age, referral order, initiating party, referring department, reason for referral, and psychiatric diagnosis. Descriptive statistics were used to analyse the distribution of variables, and the results were interpreted with comparisons to existing literature. **Result:** The study found that 59% of the patients were male, with the majority (70%) in the 19-39 years age group. First-time referrals accounted for 79% of cases. Relatives/friends initiated most referrals (76%), and the medicine department was the primary source of referrals (52%). The most common reasons for referral were abnormal behaviour (26.5%) and medically unexplained somatic complaints (11%). The most frequent psychiatric diagnoses included deliberate self-harm (24.5%) and substance use disorder (16.5%). Additionally, 11% of referrals had no psychiatric diagnosis. These results align with findings from other studies conducted in similar settings. **Conclusion:** The study highlights significant patterns in psychiatric referrals, with male patients and younger adults being the most commonly referred groups. The findings emphasize the crucial role of family members and general healthcare providers in initiating referrals. Abnormal behaviour and medically unexplained somatic complaints were the leading reasons for psychiatric consultation. The study underscores the importance of early psychiatric evaluation and suggests that improving awareness among healthcare providers can enhance the identification of mental health issues, thereby improving patient outcomes.

INTRODUCTION

Consultation-liaison psychiatry (CLP) operates at the intersection of psychiatry and other medical specialties, addressing the psychological and behavioural dimensions of patients in non-psychiatric settings. The importance of CLP services has grown with the increasing recognition of the bidirectional relationship between physical and mental health. Globally, approximately 30-60% of patients in medical and surgical settings are estimated

to experience psychiatric comorbidities, yet a significant proportion remains undiagnosed or undertreated.^[1,2] This underscores the necessity for effective CLP services in modern healthcare systems. Referral patterns to CLP services provide critical insights into how mental health care is integrated within broader medical frameworks. These patterns are shaped by multiple factors, including the specialties making referrals, reasons for referral, and patient demographics. Studies from developed countries report that internal medicine, oncology, and

surgery are among the most common sources of referrals to CLP services, with depression, delirium, and anxiety disorders being the most frequently encountered psychiatric conditions.^[3,4] For example, a study from the United States revealed that 41% of CLP referrals were related to delirium, followed by depressive symptoms (22%) and substance use disorders (12%).^[5] In India, the need for robust CLP services is particularly pressing due to the high burden of mental health disorders. The National Mental Health Survey (2015-16) reported that nearly 14% of India's population requires active mental health interventions, with significant underutilization of psychiatric services due to stigma and resource limitations.^[6] Referral patterns in Indian CLP services often differ from those in high-income countries due to unique sociocultural and systemic factors. For instance, referrals are frequently made for somatization disorders, medically unexplained symptoms, and treatment non-adherence.^[7] A study conducted in a tertiary care hospital in South India reported that 32.5% of referrals were for unexplained physical complaints, 25% for delirium, and 15% for depressive symptoms.^[8] Despite the critical role of CLP in addressing these challenges, there is limited literature from India that systematically examines referral patterns to CLP services. Understanding these patterns is essential for identifying gaps in service provision, improving mental health integration into general healthcare, and tailoring CLP services to meet local needs. This study aims to analyse referral patterns to CLP services at a tertiary care centre in India. Specifically, it seeks to identify the most common specialties initiating referrals, the primary reasons for referral, and the demographic and clinical characteristics of referred patients. By addressing these aspects, this study hopes to contribute to a more nuanced understanding of CLP referral practices in resource-constrained settings and inform strategies for improving mental health care delivery.

MATERIALS AND METHODS

Study Design and Setting

This cross-sectional study was conducted in the Department of Psychiatry at Pandit Bhagwat Dayal Sharma Post Graduate Institute of Medical Sciences (PGIMS), Rohtak, Haryana. PGIMS is a tertiary care teaching hospital that provides advanced medical care to the population of Haryana and neighbouring states such as Punjab, Rajasthan, Delhi, and western Uttar Pradesh. The study focused on patients referred to the consultation-liaison (C-L) psychiatry services within the hospital. The study period spanned June 2020 to May 2021, during which data were collected systematically from referred patients.

Study Population and Sampling

The study population comprised all patients referred to the C-L psychiatry services during the study period. A total of 200 consecutive patients who provided informed consent were included in the

study. There were no exclusion criteria, ensuring that all referred patients, regardless of age, gender, or clinical condition, were evaluated. This approach was designed to capture a comprehensive profile of referral patterns and clinical correlates in a real-world tertiary care setting.

Data Collection

Data were collected prospectively using a structured pro forma developed for the study. Socio-demographic details, including gender, age, marital status, education level, and occupational status, were recorded for all participants. Referral patterns were documented, including whether the patient was a first, second, or third referral to psychiatric services. The first point of contact for the patient's presenting complaints was identified through direct patient or caregiver interviews. Options included native or religious healers, general medical practitioners, psychiatric services, and general hospitals. Additionally, the initiator of the first contact, such as the patient, relatives, neighbours, colleagues, or others, was noted to assess help-seeking behaviours and pathways to care. The source of referral was documented by noting the clinical department initiating the psychiatric consultation. Referrals were categorized into departments such as medicine, surgery, obstetrics and gynaecology, orthopaedics, dermatology, ENT, or other specialties. The primary reasons for referral were carefully recorded and classified into medically unexplained somatic complaints, abnormal behaviour, substance abuse, anxiety, seizures, and others, based on the referring physician's note and patient interviews.

Psychiatric diagnoses were established by consultant psychiatrists based on the International Classification of Diseases, 10th Revision (ICD-10). Diagnoses and presenting symptoms were categorized into groups such as depression, psychosis, somatoform disorders, substance use disorders, deliberate self-harm, and other psychiatric or organic brain syndromes. Patients without psychiatric diagnoses were also recorded for further analysis.

Data Management and Statistical Analysis

All data were entered into a dedicated database and analysed using SPSS Version 16.0. Categorical variables, such as socio-demographic characteristics, referral patterns, and psychiatric diagnoses, were summarized using frequencies and percentages. Continuous variables, including age, were presented as mean and standard deviation.

Ethical Considerations

The study received ethical approval from the Postgraduate Board and Institutional Ethics Committee of PGIMS, Rohtak. All participants provided written informed consent prior to their inclusion in the study. For participants unable to provide consent due to their medical or cognitive condition, consent was obtained from their legally authorized representatives. The confidentiality and privacy of the participants were maintained throughout the study in accordance with the

Declaration of Helsinki and other applicable ethical guidelines.

RESULTS

The study included 200 participants, of whom 119 (59.0%) were male and 81 (41.0%) were female. The majority of patients (141, 70.0%) were aged between 19 and 39 years, followed by 28 (14.0%) in the 40–59 years age group. A smaller proportion included those aged <18 years (27, 13.5%) and ≥60 years (4, 2.0%) [Table 1].

Among the referred patients, the majority (158, 79.0%) were first-time referrals, indicating that most individuals sought psychiatric services during their initial presentation. A smaller proportion were second-time referrals (36, 18.0%), while only 6 patients (3.0%) had been referred for the third time [Table 2].

The majority of patients (105, 52.5%) were first seen at a general hospital before being referred for psychiatric evaluation, highlighting the crucial role of general hospitals in identifying and directing cases requiring mental health care. Medical practitioners accounted for the initial point of contact in 82 cases (41.0%), reflecting their substantial contribution to the referral chain. Only a small proportion sought help from psychiatric services directly (7, 3.5%) or native/religious healers (6, 3.0%), indicating that direct access to specialized mental health care or alternative healing systems was less common [Table 3].

The majority of psychiatric referrals were initiated by relatives or friends of the patients, accounting for 152 cases (76.0%), underscoring their pivotal role in recognizing the need for mental health care and facilitating access to services. Referrals initiated by the patients themselves and by neighbours were equal, each contributing 15 cases (7.5%). A smaller proportion of referrals originated from workmates or colleagues (7, 3.5%), while police involvement was observed in 3 cases (1.5%), often associated with acute behavioural disturbances or emergencies. Other sources of initiation, including community figures or unidentified individuals, constituted 8 cases (4.0%) [Table 4].

The majority of psychiatric referrals originated from the Department of Medicine, which accounted for 104 cases (52.0%), reflecting the high likelihood of mental health concerns being identified in patients undergoing medical treatment. Surgical departments contributed 40 referrals (20.0%), often in the context of post-operative or trauma-related psychological issues. Obstetrics and Gynaecology accounted for 17

referrals (8.5%), highlighting the recognition of psychiatric needs in maternal and reproductive health contexts. Orthopaedics contributed 9 cases (4.5%), with referrals potentially related to chronic pain or disability-associated psychological impacts. Dermatology and ENT departments made minimal contributions, with 1 case (0.5%) and 4 cases (2.0%), respectively. Referrals classified as "Others," including less frequent specialties or external sources, represented 25 cases (12.5%), emphasizing the diverse avenues through which psychiatric needs are identified in a general hospital setting [Table 5]. The most common reasons for psychiatric referrals were abnormal behaviour, which accounted for 53 cases (26.5%), and substance abuse, which contributed 27 cases (13.5%). Medically unexplained somatic complaints were identified in 22 cases (11.0%), indicating a significant number of patients presenting with physical symptoms that lacked a clear medical explanation. Anxiety was noted as a reason for referral in 10 cases (5.0%), while another 10 cases (5.0%) were referred due to seizures. Depression was a less frequent cause, with only 4 cases (2.0%). Headache and sexual problems were identified as referral reasons in 3 (1.5%) and 2 (1.0%) cases, respectively. A large proportion of referrals, 69 cases (34.5%), were categorized under "Others," encompassing a broad range of miscellaneous concerns not specifically listed in the categories above [Table 6].

The diagnoses and symptoms identified in the psychiatric referrals revealed a wide range of conditions. Deliberate self-harm was the most prevalent diagnosis, accounting for 49 cases (24.5%). Substance use disorder was also common, representing 33 cases (16.5%). Organic brain syndrome was diagnosed in 18 cases (9.0%), while schizophrenia/psychosis was identified in 14 cases (7.0%). Dissociative disorder was noted in 10 cases (5.0%), and delirium occurred in 8 cases (4.0%). Anxiety disorder, tension-type headache, and somatoform disorder each had a lower frequency, with 3 (1.5%), 3 (1.5%), and 5 (2.5%) cases, respectively. Depression was diagnosed in 7 cases (3.5%), while adjustment disorder was present in 6 cases (3.0%). Seizures were reported in 4 cases (2.0%), and insomnia was also noted in 4 cases (2.0%). A smaller number of referrals had diagnoses of bipolar affective disorder (2 cases, 1.0%), dementia (1 case, 0.5%), and sexual problems (9 cases, 4.5%). Interestingly, 22 referrals (11.0%) had no psychiatric diagnosis, indicating that in some cases, the underlying psychiatric condition was not clearly identified [Table 7].

Table 1: Detailed Socio-Demographic Characteristics of Patients Referred for Psychiatric Consultation.

Variable	Frequency	Percentage (%)
Gender		
Male	119	59.0%
Female	81	41.0%
Age Group		
<18 years	27	13.5%

19–39 years	141	70.0%
40–59 years	28	14.0%
≥60 years	4	2.0%

Table 2: Patterns of Referral Based on Referral Order.

Referral Order	Frequency	Percentage (%)
First Referral	158	79.0%
Second Referral	36	18.0%
Third Referral	6	3.0%

Table 3: Distribution of Initial Points of Contact Among Referred Patients.

First Seen By	Frequency	Percentage (%)
Native/Religious Healer	6	3.0%
Medical Practitioner	82	41.0%
Psychiatric Services	7	3.5%
General Hospital	105	52.5%

Table 4: Profiles of Initiators Responsible for First Contact with Healthcare.

Initiator	Frequency	Percentage (%)
Patient himself/herself	15	7.5%
Relatives/Friends	152	76.0%
Neighbours	15	7.5%
Workmates/Colleagues	7	3.5%
Police	3	1.5%
Others	8	4.0%

Table 5: Departmental Sources of Referral to Psychiatric Services.

Department	Frequency	Percentage (%)
Medicine	104	52.0%
Surgery	40	20.0%
Obstetrics & Gynaecology	17	8.5%
Orthopaedics	9	4.5%
Dermatology	1	0.5%
ENT	4	2.0%
Others	25	12.5%

Table 6: Specific Reasons for Psychiatric Referrals Across Departments.

Reason	Frequency	Percentage (%)
Medically Unexplained Somatic Complaints	22	11.0%
Anxiety	10	5.0%
Abnormal Behaviour	53	26.5%
Substance Abuse	27	13.5%
Depression	4	2.0%
Headache	3	1.5%
Seizures	10	5.0%
Sexual Problems	2	1.0%
Others	69	34.5%

Table 7: Distribution of Psychiatric Diagnoses and Symptomatic Presentations

Diagnosis/Symptoms	Frequency	Percentage (%)
Depression	7	3.5%
Bipolar Affective Disorder	2	1.0%
Tension-type Headache	3	1.5%
Somatoform Disorder	5	2.5%
Anxiety Disorder	3	1.5%
Deliberate Self-Harm	49	24.5%
Adjustment Disorder	6	3.0%
Dissociative Disorder	10	5.0%
Organic Brain Syndrome	18	9.0%
Schizophrenia/Psychosis	14	7.0%
Substance Use Disorder	33	16.5%
Dementia	1	0.5%
Seizures	4	2.0%
Delirium	8	4.0%
Insomnia	4	2.0%
Others	9	4.5%
No Psychiatric Diagnosis	22	11.0%

DISCUSSION

This study provides an in-depth exploration of the socio-demographic characteristics, referral patterns, reasons for psychiatric consultation, and diagnoses among patients referred for psychiatric evaluation.

In this study, male patients represented a larger proportion of the referred individuals (59.0%) compared to female patients (41.0%). This is consistent with the findings of Pingali et al., who observed a higher rate of psychiatric referrals in men in Indian clinical settings.^[9] This could be attributed to the societal expectation that men are less likely to seek mental health care independently and often present with more severe symptoms that prompt referrals. However, this gender disparity contrasts with studies in Western countries, such as those by Grassi et al., where women are more likely to seek psychiatric help, possibly due to different cultural and social norms.^[10] In terms of age, the largest proportion of referrals were from individuals aged 19-39 years (70.0%), which aligns with findings from Mathur et al., who also reported a high prevalence of psychiatric referrals among young adults.^[11] This age group is typically under high emotional and psychological stress due to academic, professional, and family pressures, making them particularly vulnerable to mental health issues.

Referral order analysis revealed that a significant proportion of patients were first-time referrals (79.0%), with second-time referrals at 18.0% and third-time referrals at 3.0%. This reflects a common trend observed in the work of Grover et al., who noted that the majority of psychiatric referrals are for acute or newly developing psychiatric symptoms.^[12] The relatively low percentage of repeat referrals suggests that either patients resolve their issues after the first intervention or, alternatively, that there may be challenges in the continuity of care. In a study by Challapallisri et al., it was found that repeat psychiatric consultations often indicate chronicity in mental health conditions, especially in the absence of adequate follow-up care, which could also be a factor in our study population.^[13]

Our study found that most patients were initially seen at general hospitals (52.5%) or by medical practitioners (41.0%), highlighting the critical role of general healthcare providers in identifying and referring psychiatric cases. This is consistent with a study by Hashim et al., which reported that general hospitals are often the first point of contact for psychiatric evaluations, as they serve as the primary healthcare providers in India.^[14] The reliance on general hospitals for psychiatric referrals may be due to limited access to specialized mental health services, particularly in rural areas. The low proportion of patients initially seen by native or religious healers (3.0%) contrasts with study by Ajmal et al., which have highlighted the persistence of traditional healing practices in mental health care in rural India.^[15] While the relatively low number of

religious healers in this study could reflect urbanization and greater access to formal healthcare, it also suggests a shift in patient preferences towards seeking medical care at general hospitals.

The majority of referrals were initiated by relatives or friends (76.0%), which aligns with findings from Grover et al., who observed that family members are often the first to recognize signs of mental illness in a patient.^[16] This finding emphasizes the vital role of the family as a support system in the early detection and intervention of mental health conditions. Study by Kumar et al., have similarly highlighted that in Indian culture, mental health issues are often recognized by family members rather than by the affected individuals themselves, who may be reluctant to acknowledge or seek help for mental health problems due to stigma.^[17]

The highest number of referrals in this study came from the medicine department (52.0%), followed by surgery (20.0%) and obstetrics & gynaecology (8.5%). This distribution is in line with the findings of Kumar et al., who found that general medicine departments frequently refer patients with psychiatric symptoms that may be secondary to medical conditions, such as chronic diseases or medication side effects.^[18] The high number of referrals from the medicine department indicates a need for better awareness and training in recognizing psychiatric symptoms among general healthcare providers, particularly in a setting like ours, where mental health resources are limited. Study by Chakravarty et al., have demonstrated that medical professionals often miss psychiatric diagnoses, leading to unnecessary referrals to specialized psychiatric care.^[19] The relatively lower referrals from specialized departments like dermatology, ENT, and orthopaedics (7.0% combined) suggest that psychiatric referrals are more commonly associated with general medical or surgical issues rather than specialized conditions.

The most common reasons for referral were abnormal behaviour (26.5%) and medically unexplained somatic complaints (11.0%), which is consistent with findings by Tekkalaki et al., and Reddy et al.^[20,21] Abnormal behaviour, including agitation, aggression, and withdrawal, is often the most visible manifestation of psychiatric disorders, prompting medical practitioners to seek psychiatric evaluation. Medically unexplained somatic complaints, such as chronic pain, fatigue, and digestive disturbances, are frequently associated with somatization disorder, anxiety, and depression. The high prevalence of these complaints in our study emphasizes the need for psychiatric evaluation when medical conditions cannot fully explain a patient's symptoms, as psychiatric disorders often manifest in physical symptoms. Substance abuse (13.5%) and anxiety (5.0%) were also significant reasons for referral, reflecting the growing burden of addiction and anxiety-related disorders in India, which have been highlighted in studies by Settem et al., and Holikatti et al.^[22,23]

The most common psychiatric diagnoses were deliberate self-harm (24.5%) and substance use disorder (16.5%), which align with the findings of Naskar et al., and Patra et al., who reported a high prevalence of self-harm and substance use among psychiatric patients in India.^[24,25] Self-harm is often linked to underlying conditions such as depression, anxiety, and personality disorders, as well as socio-economic stressors. The high prevalence of substance use disorders in our study reflects the growing challenges of addiction in the country, which have been reported in recent studies by Goyal et al.^[26] Schizophrenia and psychosis (7.0%) were also common diagnoses, consistent with the findings of Dua et al., who reported a significant prevalence of psychotic disorders in Indian psychiatric referrals.^[27] This highlights the importance of early intervention and appropriate management for patients with severe psychiatric conditions. The 11.0% of patients with no psychiatric diagnosis suggest that there may be challenges in accurately diagnosing mental health disorders, possibly due to the overlap of psychiatric symptoms with medical conditions or the underreporting of symptoms by patients.^[28,29,30]

CONCLUSION

In conclusion, this study provides a comprehensive overview of the socio-demographic characteristics, referral patterns, and psychiatric diagnoses among patients referred for psychiatric evaluation. The findings suggest that early detection, family involvement, and an integrated approach to care involving general healthcare providers are essential for improving mental health outcomes. Future studies should focus on improving the training of medical professionals in recognizing psychiatric symptoms, enhancing accessibility to mental health services, and further investigating the socio-cultural factors that influence psychiatric care in India. Additionally, there is a need for continued research into the long-term outcomes of psychiatric referrals and the effectiveness of treatment interventions.

REFERENCES

1. DE Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011;10(1):52-77.
2. Goldman ML, Mangurian C, Corbeil T, et al. Medical comorbid diagnoses among adult psychiatric inpatients. *Gen Hosp Psychiatry*. 2020;66:16-23.
3. Grover S, Sahoo S, Aggarwal S, Dhiman S, Chakrabarti S, Avasthi A. Reasons for referral and diagnostic concordance between physicians/surgeons and the consultation-liaison psychiatry team: An exploratory study from a tertiary care hospital in India. *Indian J Psychiatry*. 2017;59(2):170-5.
4. Barra BJ, Barahona M, Varela LF, et al. A Cross-Sectional, Retrospective, and Comparative Study between Delirium and Non-Delirium Psychiatric Disorders in a Psychogeriatric Inpatient Population Referred to Consultation-Liaison Psychiatry Unit. *Medicina (Kaunas)*. 2023;59(4):693.
5. Murthy RS. National Mental Health Survey of India 2015-2016. *Indian J Psychiatry*. 2017;59(1):21-6.

6. Keertish N, Sathyaranayana MT, Kumar BG, Singh N, Udageve K. Pattern of psychiatric referrals in a tertiary care teaching hospital in southern India. *J Clin Diagn Res*. 2013;7(8):1689-91.
7. Grover S, Kathiravan S, Dua D. Delirium Research in India: A Systematic Review. *J Neurosci Rural Pract*. 2021;12(2):236-66.
8. Mishra S, Mudgal V, Mathur R, Niranjana V, Pal V. A Secondary Analysis of the Prevalence and Clinical Profile of Psychiatric Referrals of Delirium in a Tertiary Care Hospital in Central India. *Cureus*. 2024;16(11):e74797.
9. Pingali S, Joopaka AK, Jangam RV, Umashankar M. Study of referrals to department of psychiatry in tertiary care general hospital setting. *Telangana J Psychiatry*. 2020;6(2):166-9.
10. Grassi L, Mitchell AJ, Otani M, et al. Consultation-liaison psychiatry in the general hospital: the experience of UK, Italy, and Japan. *Curr Psychiatry Rep* 2015;17(6):44.
11. Mathur P, Sengupta N, Das S, et al. A study on pattern of consultation liaison psychiatric service utilization in a tertiary care hospital. *J Res Psychiatr Behav Sci* 2015;1:11-6.
12. Grover S, Avasthi A. Consultation-liaison psychiatry services: A survey of medical institutes in India. *Indian J Psychiatry* 2018;60:300-6.
13. Challapallisri V, Dempster LV. Attitude of doctors towards mentally ill in Hyderabad, India: Results of a prospective survey. *Indian J Psychiatry*. 2015;57:190-5.
14. Hashim U, Kumar RS, Philip M. Consultation-liaison psychiatric service utilization by suicide attempters. *Indian J Psychiatry*. 2018;60:427-32.
15. Ajmal IT, Babu EPK, Baskaran R, Prashaanth. A study on the prevalence of psychiatric morbidity in postoperative patients who have undergone major abdominal surgeries. *M K J Dent Med Sci*. 2017;16(3):57-8.
16. Grover S, Avasthi A. Consultation-liaison psychiatry in India: Where to go from here?. *Indian J Psychiatry*. 2019;61:117-24.
17. Kumar A, Kakati AK, Nath K, et al. Psychiatric consultation in out-of-hours casualty/emergency department. *Dysphrenia* 2012;3(2):149-52.
18. Kumar P, Chaudhary R, Bhalla JK, Gupta A. Pattern of Inpatient Consultation-liaison Psychiatry Utility in a Tertiary Care Hospital. *Int J Appl Basic Med Res*. 2023;13(1):34-9.
19. Chakravarty S, Nandi S, Bhandari SS, Das S. A Study on the Patterns of Psychiatric Referrals in a Tertiary Care Hospital in the North-Eastern Part of India. *J Evol Med Dent Sci*. 2020;9(31):2217-22.
20. Tekkalaki B, Tripathi A, Arya A, Nischal A. A Descriptive Study of Pattern of Psychiatric Referrals and Effect of Psychiatric Intervention in Consultation-Liaison Set Up in a Tertiary Care Center. *Ind J Social Psychiatry* 2017;33(2):165-70.
21. Reddy VV, Datt AV. Referrals to psychiatry in a rural teaching hospital. *J Basic Clin Res*. 2016;3:11-7.
22. Settem J, Nandamuri T, Vijaya Gopal M. Referral patterns in consultation liaison psychiatry in a tertiary hospital. *J Evol Med Dent Sci*. 2019;8:2157-61.
23. Holikatti PC. Pattern of psychiatric referrals to psychiatric unit in a tertiary care medical college. *Telangana J Psychiatry*. 2016;2:73-5.
24. Naskar S, Nath K, Victor R, Saxena K. Utilization of emergency psychiatry service in a tertiary care centre in North Eastern India: A retrospective study. *Indian J Psychol Med*. 2019;41:167-72.
25. Patra P, Divinakumar KJ, Prakash J, Patra B, Chakraborty R. Clinico-psycho-social profile of patients brought under consultation-liaison psychiatry care in a large tertiary care referral hospital. *Ind Psychiatry J*. 2017;26:24-7.
26. Goyal S, Sagar R, Sharan P. Sociodemographic profile and psychiatric diagnosis of patients referred to consultation-liaison psychiatric services of general hospital psychiatric unit at a tertiary care center. *J Ment Health Hum Behav*. 2017;22:45-9.
27. Dua D, Grover S. Profile of patients seen in consultation-liaison psychiatry in India: A systematic review. *Indian J Psychol Med*. 2020;42:503-12.
28. Tveit OG, Ruud T, Hanssen-Bauer K, Haavet OR, Hussain A. An explorative study of factors associated with treatment in specialized mental health care centers among GP patients in Norway. *BMC Health Serv Res*. 2021;21(1):960.
29. Chen KY, Evans R, Larkins S. Why are hospital doctors not referring to Consultation-Liaison Psychiatry? – a systemic review. *BMC Psychiatry* 2016;9:16(1):390.
30. De Giorgio G, Quartesan R, Sciarma T, et al. Consultation-Liaison Psychiatry – from theory to clinical practice: an observational study in a general hospital. *BMC Res Notes* 2015;8:475.