

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

PART 1: THE NEED FOR AND RESEARCH DESIGN ADOPTED TO STUDY REFERRALS RECEIVED BY A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL

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ABSTRACT

In order to receive holistic health care, patients requiring psychiatric care, need to be referred to psychiatric services. The first part of this report reviews the need to analyse the referrals received by a psychiatric unit in a general hospital in the Republic of South Africa. The research design adopted to study this phenomenon will also be addressed. The research results, obtained from analysing the referred patients' records, will be discussed in Part 2 of this report.

OPSOMMING

Ten einde holistiese gesondheidsorg te ontvang, moet pasiënte, wat psigiatriese sorg benodig, na psigiatriese dienste verwys word. Deel 1 van die verslag verskaf 'n oorsig oor die noodsaaklikheid om die verwysings te ontleed, wat deur 'n psigiatriese eenheid in 'n algemene hospitaal in Suid-Afrika ontvang is. Die navorsingsontwerp wat aanvaar is om die verskynsel te bestudeer word ook bespreek. Die navorsingsresultate, wat bekom is deur die verwysde pasiënte se rekords te bestudeer, sal in Deel 2 van die verslag bespreek word.

INTRODUCTION AND BACKGROUND INFORMATION

Holistic health care implies that psychiatric health care services are rendered to clients who need such care. The purpose of this research was to investigate the utilisation of a psychiatric unit in one general hospital in the Western Cape Province by analysing the 403 referrals the unit received from 1 January 2000 to 30 June 2000. The population for this research comprised all the patients referred to this specific psychiatric unit in this general hospital. Patients were referred to the psychiatric

unit from the casualty department, from the outpatient department and from a number of inpatient departments. The assumption underlying this research was 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, HIV/AIDS, or the prospect of dying. Even though a psychiatric unit might be operating within a general hospital, it could not be assumed that patients requiring psychiatric treatment would be referred to this unit.

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 feedback provided by the psychiatric unit to the referring units was also investigated. The investigation was based on a review of national and international literature relevant to the referral of patients to psychiatric units. (Relevant literature will be addressed during the discussion of the research findings in Part 2 of this report).

The need for effective psychiatric services in the Republic of South Africa

More and more psychiatric patients are being treated in general hospitals (Ashley-Smith, 1991:1). It was assumed that by establishing psychiatric units in general hospitals, the need to treat all patients holistically would be met. However, general hospitals without psychiatric units might be unable to provide appropriate psychiatric care. This was substantiated by the literature review of research done in this field (Ashley-Smith, 1991; Gagiano, 1992; Gous, 1992; Granville, 1993; Hart, 1992; Savoca, 1999; 33rd Subcommittee Mental Health Matters, 1993; Uys & 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 health care practitioners.

Gagiano (1992:311) 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 from their communities and treated in isolation. The expense and the "less effective" treatment programme might have affected the number of referrals to psychiatric services from other health care services.

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 (Gous, 1992:316). Lack of the necessary psychiatric knowledge could affect the referral practices of physicians in primary health care settings.

Hart (1992:331) maintained that the historical problems of psychiatric services dated back to the separation of psychiatric services from general medical services in the RSA. The stigma of going to a specialised psychiatric hospital might have influenced the number of referrals to psychiatric units. Referrals and compliance rates might increase with decreased stigmatisation of having a psychiatric illness and being treated at a psychiatric unit in a general hospital, rather than in a psychiatric hospital.

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. Similar recommendations were made by the 33rd Subcommittee Mental Health Matters (1993:9) emphasising that there was a need for consultative psychiatric services at the secondary health care level in the RSA, which did not exist at that time (1993). As there were limited psychiatric services available, the referral rates were almost non-existent.

The first psychiatric outpatient services in the RSA were established during 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 remained separated from general medicine.

Since the implementation of Regulation R425 of 1985, more in-depth theoretical and practical training has been given to nursing students in the RSA (SANC, Regulation R425, 1985, paragraph 1(9)). This implied that more nurses would be competent to handle psychiatric issues, including appropriate referrals of patients to psychiatric units.

A study done in the Gauteng Province of 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 noted that no formal expert counselling was provided to patients before and after amputations 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).

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). Specialisation by practitioners could be a contributory cause to the discontinuity of patient care across hospital and community boundaries (Gous, 1992:316). 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 Alzheimer's disease who require psychological support and genetic counselling to enable them to function optimally (Pearle, 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.

The National Health Care Plan and Policies of the RSA

The African National Congress (ANC) stated in their National Health Plan (NHP) that there was a poor multi-disciplinary approach to patient care in the RSA (ANC, 1994:45). This 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 to ensure multi-sectoral and integrated approaches to mental health services. The integration of mental health care and primary medical health care could enhance the quality of holistic patient care. If these services were integrated, the overall cost-effectiveness of the health services could be improved (Nickels & McIntyre, 1996:522). This study investigated to what extent the physical and the psychiatric aspects of the patients were integrated by analysing the referrals received by a psychiatric unit in a general hospital.

Olfsons' study (1993:277) done in the USA, showed that only a small number of general hospitals provided the full complement of services, including psychiatric services, implying that many patients might not receive holistic care. Health care providers need to work together in planning, implementing and evaluating health care to ensure holistic health care (Lindeke, 1998:213). Interdisciplinary health care team members must promote and facilitate quality and holistic care. Shultz (1997:26) notes that interdisciplinary collaboration fosters healthier communities.

Research problem

In the RSA, psychiatry has for many years been treated as a separate entity in health care (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 effective reciprocal referral systems. Unless a psychiatric unit in a general hospital receives referrals from other units, it cannot render psychiatric services to persons requiring such services. This research analysed 403 referrals received by a psychiatric unit in a general hospital over a period of six months, in an effort to evaluate the effectiveness of referrals sent to this psychiatric unit. The underlying assumption was that improved referrals to the psychiatric unit, would improve the quality of holistic care rendered to patients utilising the services of the specific general hospital - with possible generalisations to other similar health care situations.

The aim and objectives of analysing the referrals received by a psychiatric unit in a general hospital

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. It analysed the content of the referrals, namely whether there were sufficient details about the patients' conditions and the requests for services 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 sources.

Permission to conduct the research

The management of the general hospital, where the research was conducted, granted permission that the records of referrals to the psychiatric unit could be studied. Both management of the hospital and the staff of the psychiatric unit approved the checklist prior to the data collection phase. Permission was not obtained from any patient, as only the records were studied. No patient's name, hospital number or treatment would be mentioned in any report. Only the frequencies and percentages obtained from the analysis of the data obtained from the referral records and patients' records would be reflected in any reports. No patient's confidentiality or anonymity could be affected by this report.

Research questions

Specific research questions guided the empirical research, as implemented by specific subsections of the checklist, which addressed issues relevant to respective research questions.

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

This question's objective was to examine the biological profile of the patients referred. Age, sex, marital status, employment status and race of the referred patients identified the extent to which each group was referred.

- What was the source of the referrals?

With this question, the objective was to determine which health care team members referred the most and which referred the least patients to the psychiatric unit in a general hospital. The hospital departments which referred, or which failed to refer patients to the psychiatric unit were also identified.

- 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 referred. If the referral was appropriately sent to the psychiatric unit, the question further examined whether the referral was sent to the correct team member. A further objective of this question was to assess the number of referrals that were unnecessarily sent to the psychiatric unit as urgent referrals, and those that were not but should have been referred urgently.

- 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 received appropriate interventions.

- What was the compliance rate of referred patients keeping their appointments with the psychiatric unit?

The objective of this question was to determine how many of the referrals kept their appointments so that defaulters could be traced and measures instituted to increase compliance, if necessary.

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

The objective of this question was to assess how soon the patients were seen at the psychiatric unit subsequent to being referred. This information could help in assessing whether the psychiatric unit had an effective system for attending to patients and whether the unit was able to see urgently referred patients within a reasonable period of time.

- What were the diagnoses of the patients referred?

The diagnoses of the patients referred were monitored to assess whether any diagnoses were under or over

represented in the referrals.

- 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, medication, therapy, admission, referral elsewhere or completion of forms.

- 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/person.

Assumptions underlying the analysis of referrals received by a psychiatric unit in a general hospital

Assumptions underlying the study also followed from the assumptions in the Whole Person's Theory postulated by ME Rogers (George, 1995:166), which states 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/her life experiences. Thus the assumption that is made in the theory is that psychiatric input will 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). Thus this assumption maintains 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). This theory assumes that, because of this exchange, the individual is an open system, accommodating the

assumption that psychiatric inputs could influence the patients' health.

These two theories emphasise the importance of viewing a person in totality as a whole - not only as his/her illnesses but also the reactions, environments and past experiences are important.

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 delays in commencing treatment, difficulties for families to visit and participate in treatment, and high costs for the patients and hospitals (Ashley-Smith, 1991:12). Referrals to a psychiatric unit in a general hospital could significantly reduce these costs to individual patients and to the health care services.
- There is a high relapse rate in the RSA due to the lack of primary intervention psychiatric programmes which referrals could alleviate (Gagiano, 1992:311).
- Only complicated and treatment resistant cases should be treated in psychiatric hospitals and others should be referred to psychiatric units in general hospitals for consultation (Abiodun, 1990:273).
- Primary care physicians in the RSA might not be equipped to deal with psychiatric problems in their practices, which could account for up to 75,0 percent of their case load (Gous, 1992:315). Referrals to specialised psychiatric services should be one aspect of providing holistic health care.
- It is important to maintain 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 to psychiatric units will enhance the holistic health care rendered to the

RSA's people.

Depressive disorders account for more disability than medical illnesses (Lyness & Caine, 1993:910), therefore it is necessary to have a holistic approach to health care. This can be achieved through referrals to appropriate health disciplines, including psychiatric services. Indeed effective referrals to psychiatric services could alleviate the demands made (erroneously) on other medical and health care facilities, if more disabilities could be attributed to psychiatric rather than physical causes.

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 required to do so.

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 specialists (Gous, 1992:315). It involves a close working relationships between a mental health care professionals and other health care professionals with the aims of providing mental health knowledge and skills in non-psychiatric settings. It is a process of communication between two professionals (Uys & Middleton, 1997:71). In this study consultation-liaison 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 patient's 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). In this study it was used in the context of the patient's 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).

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. (All the referrals to the psychiatric unit could only be made from other departments in this hospital due to the unique nature of this hospital). The study also investigated whether the unit had been used appropriately for referrals from other hospital departments.

Referrals to only one psychiatric unit in one general hospital were studied, limiting the generalisability of the results. The data was collected over a six month period, 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 only. This limited the scope of the study in that data from observations and experiments could not be included. No data was collected about the satisfaction of the consumers regarding the services received from the psychiatric unit. This research did not attempt to investigate either the relapse and/or recovery rates of referred patients.

RESEARCH DESIGN

A research design "... can be viewed as a kind of cost-benefit balancing: it is a plan for a piece of research that is constructed to maximise the validity of its findings, subject to the costs, and practical difficulties of doing so" (Terre Blanche & Durrheim, 1999:312). The data for this study were collected by using a checklist, specifically

designed for the study by incorporating aspects from the literature reviewed. Data were collected from referral letters received by the psychiatric unit, patients' notes and the return letters sent to the referral sources. The checklist was constructed to give structure and consistency to the data collection process and to ensure that quantifiable data were collected (Polit & Hungler, 1993:227). (The different sections of the checklist attempted to obtain information relevant to specific research questions - as discussed under the section in this article relevant to the research problem). 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 (Burns & Grove, 1999:24).

Reliability of the checklist

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 it yielded consistent results on repeated measurements on corresponding parts of the checklist (Waltz, 1991:86).

The checklist proved to be reliable when comparing responses obtained to 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, 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. Similar comparisons with other questions also showed that the checklist could be accepted as providing reliable data.

Validity of the checklist

The accuracy of the checklist to actually test what 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).

- *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). These assessors included a consultant psychiatrist, the head of a psychology department, a chief professional nurse - head of a psychiatric unit, a private psychiatrist, and a professional nurse working in an outpatients' department. Recommendations from these five assessors included that certain items on the checklist needed to be rephrased - these suggestions were implemented.
- *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 - as judged by the five assessors (Treece & Treece, 1986:130).

Research population

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 referrals from the departments in a general hospital to the psychiatric unit in this general hospital. The criterion 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 failed to keep their appointments (Burns & Grove, 1999:403). All subjects came from one source, namely the psychiatric unit in a general hospital in the Western Cape. The period of six months was decided on because it was expected to yield approximately 400 referrals. This was thought to be a sufficiently large sample for the purpose of this study. The eventual population studied

comprised 403 records of patients referred to the psychiatric unit in a general hospital from 1 January until 30 June 2000.

The advantages and disadvantages of using records to obtain data

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 patients' files. Data from patients' files included who referred the patient, details about the patient, the time between referral and appointment, tests done, other interventions and the feedback provided by the psychiatric unit to the referral source.

Advantages of using records to obtain data

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 might not be available simultaneously to the researcher. 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 obtained from 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 materials available 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).

Disadvantages of using records to obtain data

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 impossible to trace the missing data (Treece & Treece, 1986:265). Due to the vast numbers of records available

for research, information could be cross-referenced, namely between the referral letters and the patients' files. Another disadvantage of records is that recorded errors might remain undetected because the recorded data is taken as representing the true facts (Treece & Treece, 1986:265). This possibility was addressed by cross-referencing any dubious and/or incomplete data, namely between the referral letters and patients' 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 letters with data in the patients' notes. Access to records could be very difficult (Treece & Treece, 1986:267), but this was overcome by approaching the authorities for permission and maintaining positive relationships with the staff handling the records. Handwritten records could be impossible to read (Treece & Treece, 1986:266). This problem was overcome by recognising the signature of the person who wrote the referral and asking that person for interpretations (which was very time-consuming) or asking an experienced typist who was used to deciphering the handwriting of different staff members to read the illegible handwritten records. Although misinterpretations could occur as a result of illegible handwriting on some records, this possibility was minimised by consulting the authors and/or a typist experienced in reading the staff members' handwritings.

Data obtained from patients' records could be termed "secondary data" (McEvoy, 1999:33) because information was originally documented for other purposes, not for research as such. But this was turned into an advantage in this study because records were not biased to fit what the researcher was looking for, nor expected to find.

Pretesting the checklist

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 for these purposes. The results obtained were analysed with the assistance of a statistician to identify any potential problems. All records utilised for the pretest were excluded from the research population. The pretest's results were kept strictly confidential so as not to influence the subsequent data gathering process in any way.

After the pretest's data was analysed, the checklist was amended because 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 revised to clarify ambiguities or problems, which could arise when using the checklist.

Data analysis

With the help of a statistician, the data was analysed, using the Statistical Package for the Social Sciences (SPSS). The data was grouped and analysed in accordance with the specific research questions which guided this research. (The analysis, presentation and discussion of the research results will be addressed in Part 2 of this report).

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

Referrals to only one psychiatric unit in one general hospital were studied, limiting the generalisability of the results. 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 services received from the psychiatric unit. This research did not attempt to investigate either the relapse and/or recovery rates of consumers.

CONCLUSION

The need to analyse referrals received by a psychiatric unit in a general hospital was discussed as well as the research design adopted to obtain this information. Part 2 of the report will provide an analysis of the research results and compare and contrast these findings with those reported by relevant literature sources.

LIST OF REFERENCES

- ABIODUN, O 1990: Mental health and primary care in Africa. **East African Medical Journal**, 4:273-278.
- AFRICAN NATIONAL CONGRESS 1994: A national health plan for South Africa. Maseru: Bahr Mapping and Printing.
- ANC see African National Congress.
- ASHLEY-SMITH, A 1991: A psychiatric service at a community hospital. Cape Town: University of Cape Town.
- BAILEY, KD 1995: Methods of social research. London: Free Press.
- BRONDON-WOOD, W 1990: Nursing research. St Louis: Mosby.
- BURNS, N & GROVE, SK 1999 Understanding nursing research. Philadelphia: Saunders.
- DAVIS, G 1998: Nursing's role in pain management. **Nursing Outlook**, 48:19-23.
- DOBSON, L 1990: Research methods in psychiatry. Oxford: Alden.
- GAGIANO, C 1992: Community psychiatry. **Continuing Medical Education**, 10(3):311-315.
- GEORGE, JB 1995: Nursing theory. New York: Prentice Hall.
- GOUS, P 1992: Consultation liaison in community psychiatry. **Continuing Medical Education**, 10(3):315-320.
- GRANVILLE, K 1993: Recent advances in clinical psychiatry. London: Churchill Livingstone.
- HART, GA 1992: A plan for community psychiatry. **Continuing Medical Education**, 10(3):331-333.
- LINDEKE, L 1998: Maintaining professional integrity in the midst of interdisciplinary collaboration. **Nursing Outlook**, 46:213-218.
- LYNESS, JM & CAINE, ED 1993: Depressive symptoms, medical illness and functional status in depressed psychiatric inpatients. **American Journal of Psychiatry**, 150(6):910-914.
- MCEVOY, P 1999: Using patients' records as a source of data. **Nursing Standard**, 13(36):33-36.
- NICKELS, MW & MCINTYRE, JS 1996: A model for psychiatric services in primary care settings. **Psychiatric Services**, 47(5):522-527.
- OLFSON, M 1993: The array of psychiatric services in general hospitals. **General Hospital Psychiatry**, 15:277-283.
- PEARLE, G 1997: Diagnosis of Alzheimer's disease in a community hospital based programme. **Southern Medical Journal**, 90(5):720-729.
- PILLAY, YG & SUBEDAR, H 1992: Primary mental health care. **Curationis**, 15(2):5-7.
- POLIT, D & HUNGLER, B 1993: Nursing research, principles and methods. Philadelphia: Lippincott.
- Regulation R425 see South African Nursing Council.
- SANC see South African Nursing Council.
- SAVOCA, E 1999: Psychiatric co-morbidity and hospital utilisation in the general medical sector. **Psychological Medicine**, 29:457-464.

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- SHOULTZ, J 1997: Looking beyond primary care to primary health care. **Nursing Outlook**, 45 (1):23-26.
- SOUTH AFRICAN NURSING COUNCIL (SANC) 1985: Minimum requirements for the education and guide concerning the teaching of students in the programme leading to registration as a nurse (general, psychiatric and community) and midwife. (Based on Regulation RR425, 1985.) Pretoria: SANC.
- STANHOPE, M & LANCASTER, J 1992: Community health nursing. Toronto: Mosby.
- SWARTZ, S 1992: Chroniese veralgemeende angstersteuring. **Continuing Medical Education**, 10(3):371-377.
- SYKES, SB 1992: The pocket Oxford dictionary. Oxford: Oxford University.
- TERRE BLANCHE, M & DÜRRHEIM, K 1999: Research in practice: applied methods for the social sciences. Cape Town: University of Cape Town.
- 33RD SUBCOMMITTEE MENTAL HEALTH MATTERS 1993: Minutes of meeting held on 21 September. Pretoria: Government Press.
- TREECE, EW & TREECE, JW 1986: Elements of research in nursing. St Louis: Mosby.
- UYS, L & MIDDLETON, L 1997: Mental health nursing: a South African perspective. Kenwyn: Juta.
- WAITE, M 1994: The little Oxford dictionary. Oxford: Oxford University.
- WALTZ, CF 1991: Measurement in nursing research. Philadelphia: Davis.
- WESSMAN, J 1994: A framework for expressing Christian values in nursing actions. **Christian Nurse International**, 10(2):10-12.