

Consultation-Liaison psychiatry in Fiji

Abstract: Objective: To examine and report the characteristics of the patients seen on the consultation-liaison (C-L) psychiatry in the main general hospital in Fiji-Islands. Method: The socio-demographic and clinical indices of all the patients referred to the C-L psychiatric service between January 1999 and June 2000 were retrieved from the computerized C-L psychiatry register and analyzed. These were compared, in certain aspects, with those of the patients seen in psychiatric hospital located within the same city. Results: The rate of referral to the C-L service was 0.4% of all hospital admission and outpatient referrals. A major reason for referral was psychiatric comorbidity (80.5%). Other reasons include social problems, neurological conditions such as epilepsy and migraine. About fifty-four percent of the patients were referred to the C-L psychiatric service by internists. The mean age of the patients seen on this service was 31.1 (SD 13.1) years, while those of psychiatric hospital patients were 32.6 (SD14.5) (inpatients) and 33.2 (SD13.9) years (outpatients). A majority of C-L patients were female and of Indian descent, while the psychiatric hospital patients were predominantly males with more indigenous Fijian inpatients but more Indian outpatients. The most common psychiatric disorders in the C-L service were depressive episode/recurrent depressive disorder (29.9%), and neurotic, stress-related and somatoform disorders (25.7%). The most common psychiatric disorders encountered in the psychiatric hospital were schizophrenia/delusional disorders (58.5% for inpatients and 52.7% for outpatients) and bipolar affective disorders (30.6% for inpatients and 27.9% for outpatients). Conclusion: The most likely person to utilize the C-L service in this population is a young adult female Indian who has been suffering from an internal medical condition, which became complicated by depression, resulting in the attending physician seeking psychiatric opinion. The C-L and psychiatric hospital patients are different in age, gender and racial distributions, and in patterns of psychiatric morbidity. The characteristics of this C-L service place it between what obtained in centres in developing countries and advanced ones.

Henry Aghanwa*

Introduction

Consultation-liaison (C-L) psychiatry is a subspecialty of psychiatry concerned with the provision of service, teaching and research at the interface of psychiatry and medicine^{1,2}. It is defined as the consultation to and collaboration with non-psychiatric doctors and other health workers in any type of health care facilities but especially the general hospital setting^{3,4}. C-L psychiatry, which is also called general hospital psychiatry, is the clinical pendant of psychosomatic medicine⁵.

Interest in C-L psychiatry became escalated in the 1930s^{2,5}. Although, C-L psychiatry established itself as an inpatient practice in the general hospital, it specializes in physical/psychiatric comorbidity and somatisation, which are the most common forms of psychiatric presentation in primary care, and in the wider community⁶. An international database on C-L psychiatry literature has recently been produced. Among other issues, this focuses on

providing seminar topics for trainees and also on guidelines for the practice^{7,8}. Recently, a centre in Australia developed and commenced the implementation of clinical indicators in C-L psychiatric service. This aimed at maintaining high quality in the practice of C-L psychiatry⁹. Enormous benefits have been derived from the practice of C-L psychiatry in western societies^{2,6,10,11}.

In spite of the advantages of C-L psychiatry, coupled with the high prevalence of psychiatric complications of physical disorders^{12,13}, the rates of C-L service utilization have been undesirably low in most developing countries¹⁴. The low rates could be due to the reluctance of some physicians and surgeons to refer their patients to the psychiatrist because of stigma. Low index of suspicion for early symptoms of mental illness may also be responsible for the poor rate of referral in developing countries¹⁴.

Fiji is a multiracial and multicultural society. Its indigenous people constitute the majority and are predominantly Melanesians. The second most populous group is the Indian race, whose forefathers were brought to Fiji-Islands through the indenture labour system^{15,16,17}. Others include Chinese, European and immigrants from other Pacific islands. Although, the cultures in this country are in a state of transition, certain aspects of the traditional systems are resistant to western influence^{17,18}. Among developing nations Fiji-Islands has relatively high rates of literacy and gross national product (GNP)¹⁹.

*Senior Lecturer (Psychiatry), Fiji School of Medicine, Suva, Fiji

According to the Fiji Medical Council register, in 1999 there were three psychiatrists on the specialist list, and they were all located in the capital city. The situation in this country seems far better than in a majority of Pacific Countries, where there are no psychiatrists at all and generalists render some psychiatric services. The practice of C-L psychiatry in Fiji, a nation with a population of 806,000¹⁹, has never been previously reported.

The extent to which the socio-demographic indices of the patients and the pattern of psychiatric morbidity encountered on the C-L psychiatric service in Fiji differs from those of other settings is not known. The objectives of this study are therefore: to examine and report the practice of C-L psychiatry in Fiji, and to compare the socio-demographic and clinical indices of the patients seen in this service with those of similar services elsewhere.

Methods

The study was conducted at the Colonial War Memorial Hospital, Suva, Fiji. This 551-bed general hospital receives referrals from outlying health care facilities within the country, and also from other South Pacific nations.

This hospital serves as the main teaching hospital for the Fiji School of Medicine, who rotate through its various departments during their clinical years. Doctors in various postgraduate programmes also have their clinical attachment in this hospital. It is a major centre for training fresh medical graduates during the pre-registration internship period.

A Consultant Psychiatrist holds a psychiatry clinic once a week. An average of 12-17 cases is seen during each clinic, mostly patients referred by other specialists. The physicians or surgeons also refer to the C-L psychiatric service inpatients requiring psychiatric evaluation.

The evaluation of any inpatient referred to the C-L psychiatry entails: understanding the reason for the referral; going through the previous case file entries; interacting with doctors and nurses on the original ward of admission about the patient's behaviour; and interviewing the patient about current and past psychiatric symptoms. Where available, a family member is also interviewed regarding relevant aspects of the patient's medical history and premorbid personality. Other tasks include carrying out investigations (including social and psychological ones), conducting mental state examination, and formulating diagnosis and a treatment plan. The cases are followed up on an outpatient basis after discharge from the general hospital and only rarely are cases transferred to the psychiatric hospital.

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On the conclusion of management or on discharge, the socio-demographic and clinical indices of the patients are entered into a computerized register. The clinical indices include the referring department, reason for the referral, primary diagnosis, findings of the psychiatrist, psychiatric diagnosis according to the International Classification of Diseases,²⁰ psychiatric management, treatment outcome and method of disposal. This C-L psychiatry register was opened in January 1999.

The data from the C-L psychiatry service at the general hospital was then compared with similar data from the Psychiatric hospital.

This review covers those patients who were seen between January 1999 and June 2000, a period of 18 months. The data on these patients, stored in the C-L psychiatry register were retrieved and analyzed for frequency distribution and compared with similar data from patients seen at St Giles Psychiatric Hospital, Suva, during the same period, using chi square and analysis of variance (ANOVA). The critical level of statistical significance was set at 0.05 and the analysis was two-tailed.

Results

The total number of patients admitted to the hospital wards and those seen by the consultants at the special outpatients departments (all specialties) were 46,391. Out of this figure 164 patients (0.4%) were referred to the C-L psychiatric service. Of the 164 patients there were 100 (61%) females and 64 (39%) males. Their distribution according to races was: 56(34.2%) Fijians, 103 (62.8%) Indians and 5 (3%) other races. The age of the patients ranged from 4 to 76 years with the mean at 31.1 (SD 13.1) years. About a half were of the Hindi faith. A majority [128(61.6%)] was in 16-45years-age-group. Unemployed persons [49(29.9%)] constituted the majority (see table 1).

A majority (80.5%) was referred because they developed psychiatric morbidity. Those presenting with a history of suicidal behaviour [50(30.1%)] also had psychiatric morbidity and were included in the above category. Regarding the source of referral, the internists referred a majority of the cases [89 (54.3%)]. Over a half (54.3%) of the sample was referred during an admission for some primary physical problems.

The mean age of the C-L patients was significantly lower than that of either the psychiatric hospital inpatients or outpatients ($p < 0.0001$). Also, unlike the psychiatric hospital patients, there were more females than males in the C-L psychiatric population. Unlike the psychiatric hospital

Table 1 Socio-demographic characteristics of the C-L patients

	(n=164)	%
Age (yr)		
< 15	12	(7.3)
16-25	52	(31.7)
26-35	38	(23.2)
36-45	38	(23.2)
46-55	19	(11.6)
55-65	2	(1.2)
> 65	3	(1.8)
Gender		
Female	100	(61)
Male	64	(39)
Employment status		
Students	31	(18.9)
Unemployed/ retired	49	(29.9)
Housewife	32	(19.5)
Artisan/police/ security-men	27	(16.5)
Farmer/Fishermen	3	(1.8)
Clerk/Salesmen	15	(9.1)
Professionals & Managerial	7	(4.3)
Race		
Fijian	56	(34.2)
Indian	103	(62.8)
Others	5	(3.0)
Religion		
Christianity	66	(40.2)
Hindi	83	(50.6)
Islam	13	(8.0)
No Religion	2	(1.2)
Referring Department		
Accident & Emergency and General Outpatients' Dept.	37	(22.6)
Medicine	89	(54.3)
Obsterics & Gynaecology	16	(9.8)
Paediatrics	3	(1.8)
Pathology	1	(0.6)
*Psychiatry	4	(2.4)
Surgery	14	(8.5)

* These four patients were being managed in the psychiatric hospital but developed medical conditions and were referred to the general hospital, and had to be managed jointly by the physician and the C-L psychiatrist.

Table 2. Comparison of the psychiatric morbidity and socio-demographic parameters of the C-L service and Psychiatric hospital

	General Hosp.		Psychiatric. Hospital		Statistics
	Patients	In-patients	Out-patients		
	(n=164)	(n=509)	(n=8384)		
Psychiatric syndromes					
Dementia/Other organic Psychoses	8 (4.9)	24 (4.7)	82 (1)		$X^2=71.53^1$
Delirium	6 (3.6)	1(0.2)	142 (1.7)		$X^2=10.83^2$
Substance Abuse	6 (3.6)	20 (4)*	0		$X^2=325.15^1$
Schizophrenia / Delusional Disorder / Acute & Transient	16 (9.7)	298 (58.5)	4422 (52.7)		$X^2=127.61^1$
Bipolar mood Disorders / Manic Episode / Other mood disorders	0	126 (30.6)	2348 (27.9)		$X^2=65.33^1$
Depres. episode/recurrent	49 (29.9)	7 (1.4)	0		$X^2=2341.85^1$
Neurotic / Stress / Somatic Behaviour syndromes.	42 (25.7)	8 (1.6)	292 (3.5)		$X^2=223.96^1$
Personality disorders	3 (1.8)**	14 (2.7)**	17 (0.2)		$X^2=92.72^1$
Child & Adolescent disorders	5 (3.1)	6(1.2)	15 (0.2)		$X^2=61.26^1$
Epilepsy / Migraine	12 (7.3)	9 (1.8)	***1061 (12.7)		$X^2=57.47^1$
Deliberate self harm	53 (32.3)****	4(0.8)****	5 (0.1)		$X^2=2461.96^1$
No ICD-10 diagnosis (but social difficulties)	20 (12.2)	8(1.6)	0		$X^2=804.09^1$
Socio-demography					
Age (in years)	31.1 (13.1)	32.6 (14.5)	33.2 (13.9)		$F=30.89^1$
Gender					
Male	64(39)	299 (58.7)	5585(66.6)		$X^2=65.81^1$
Female	100 (61)	210 (41.3)	2799(33.4)		
Race					
Fijians	56 (34)	254(49.9)	3070(36.6)		$X^2=58.53^3$
Indians	103 (63)	191(37.5)	4408(52.6)		
Others	5(3)	64(12.6)	906(10.8)		

* This condition was associated other psychiatric disorders

**A psychiatric disorder was associated with each of these personality disorders

***Eight cases were complicated by psychiatric syndromes, and were counted elsewhere

****All these were associated with psychiatric syndromes

¹df=2, p<0.0001; ²df=2, p=0.001; ³df=4, p=0.0001

inpatients but similar to its outpatients' sample, a majority of the C-L patients were Indians. (see table 2)

Psychiatric morbidity of the C-L patients compared with that of the psychiatric hospital patients

A majority [49(29.9%)] of patients were suffering from depressive episode and recurrent depressive disorder. Those suffering from neurotic, stress-related, somatoform, and behavioural disorders followed in rank [42(25.7%)]. These were mainly generalized anxiety disorder, acute stress reaction, adjustment disorder and somatization disorder. On the other hand, in the psychiatric hospital, the majority of the cases were schizophrenia like /delusional

disorder (58.5% of inpatients and 52.7% of outpatients). This was followed in rank by bipolar affective disorder (30.6% of inpatients and 27.9% of outpatients) (table 2).

The proportion of general hospital patients (8.5%) with organic psychoses, including delirium, was about three times the proportion of psychiatric hospital outpatients (2.7%) with the same conditions. Also, patients with neurotic, stress-related and somatoform disorders, which constituted the second largest proportion in the general hospital psychiatric sample (25.7%) were significantly fewer in the psychiatric hospital, inpatients (1.6%) and outpatients (3.5%). Whereas, over one-third of the general hospital psychiatric patients had comorbidity of deliber-

ate self-harm, only 0.1% outpatients and 0.8% inpatients of the psychiatric hospital had a similar comorbidity. About seven percent of the general hospital psychiatric patients and 1.8% of psychiatric hospital inpatients had various types of seizure disorders or migraine. The figure was higher in the psychiatric hospital outpatients (12.7%). Twenty (12.2%) of the general hospital psychiatric patients presented with only social difficulties without any psychiatric morbidity. A negligible proportion of the psychiatric hospital inpatients had only social problems. Comparing the psychiatric morbidity of the three groups, using chi square test, revealed significant differences in all categories ($p < 0.0001$ or $p < 0.0005$) (see table 2).

Apart from deliberate self-harm, the most common physical disorders complicated by psychiatric morbidity were obstetric complications, cardiovascular disorders, autoimmune diseases and gynaecological conditions. Head injury, seizure disorders, migraine and other neurological conditions followed, in this sequence.

Other characteristics of the C-L Psychiatric service

The attending physicians and surgeons referred mainly patients with overt features of psychiatric morbidity. In a majority of cases, before sending the referrals they notified the patients of their intention. The desire to transfer to the psychiatric hospital, the patients referred to the C-L psychiatric service, was rarely expressed by the nurses and doctors on the medical and surgical wards. Negative attitude towards the mentally ill was only demonstrated in a minority of cases on these wards. Referred patients perceived the proposed psychiatric management with mixed feelings, based on their concern about stigma and desire for effective care. Management consisted mainly of pharmacotherapy, psychological approaches and social intervention. Except those without physical comorbidity, but somatization, the psychiatrist and the referring physician or surgeon managed every case jointly.

Discussion

The practice of C-L psychiatry is not entirely new in this hospital, but like in most centres in developing countries, it had been haphazard. It was only recently that it became organized and systematic. This report on C-L psychiatry represents the first one from Fiji and the Pacific – a region with about 7.6 million people ²¹.

Patients seen in the C-L psychiatric service in this hospital were actually admitted because of their primary medical conditions. In a majority of cases, the psychiatric

comorbidity could be managed on outpatient basis if there were no associated physical disorders. Consequently, it was necessary to use psychiatric hospital inpatients and outpatients as separate comparison groups. This methodological approach enhances objectivity in the comparison of the patterns of psychiatric morbidity encountered in the general hospital and those of the psychiatric hospital.

Caution should be exercised in comparing the absolute figures of psychiatric patients seen in the two facilities. Whereas the psychiatric hospital is the only specialized facility of this type that serves the entire nation, there are many general hospitals in the country where some psychiatric cases are managed by the generalists. The implication of this arrangement of the health care facilities is that far larger numbers of psychiatric patients were seen in the psychiatric hospital compared to the main general hospital C-L service.

The fact that all the patients included in this studied population were managed and followed up by the author lends some strength to the findings. Besides, the selection included all consecutive patients. This method of sampling has minimal bias, and the findings may therefore be generalised to similar settings.

The rate of referral to the C-L psychiatric service in this centre is low (0.4%) compared with those of advanced centres in UK (0.7-1.3%) and USA (2.7-9%)^{14,22}. It is however similar to what obtains in other centres in developing countries such as Nigeria (0.5%)¹⁴ and Thailand (0.6%)²³. This low rate of referral is undesirable, especially as many advantages have been attributed to the C-L service in developed countries ^{2,6,10,11} and the rates of psychiatric

complications encountered on medical and surgical wards have been observed to be high (20-50%)^{12,13,24,25}. The low rate may be due to low index of suspicion for mental disorders early in their evolution, and the negative attitude towards psychiatry by some non-psychiatric doctors. Lack of awareness of the presence of C-L psychiatry by some doctors could be a contributory factor. The implication of this low rate of referrals was that some psychiatric disorders complicating physical disorders could have gone unnoticed or might have been managed by the attending physicians or surgeons.

From the result section, it could be seen that referrals from Paediatrics Department was 1.8% of all cases seen on the C-L service. This rate of referral from paediatricians is remarkably low which seems to be the pattern in the third world ¹⁴. This is in contrast to what obtains in Australia, where the rate of referral to the C-L psychiatric service is

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about 2% of the admissions to the children's hospital. Over 50% of the population in the South Pacific Island countries belonging to the under-20-years age group²⁷. This segment of the population should constitute a large proportion of those with psychiatric comorbidity.

About 80% of the patients referred for consultation in this study, were diagnosed as suffering from mental and behaviour disorders according to the ICD-10 criteria²⁰. This finding is similar to that of a study conducted in Finland, though the latter was limited to an inpatient sample,²⁸ the commonest psychiatric disorders were depressive episode and recurrent depressive disorders. This was closely followed in rank by minor psychiatric disorders, which included generalized anxiety disorder, acute stress reactions, adjustment disorder and somatoform disorders. This pattern of psychiatric morbidity is similar to that of an Italian or a Japanese survey of C-L psychiatry in oncology where the predominant syndromes were adjustment disorder and major affective disorder^{29,30}. It is unlike that of a similar developing country, Nigeria or Thailand, where the predominant condition was delirium^{14, 23}.

Although the prevalence of delirium was low in the environment where this study was conducted, its proportion in the general hospital population was twice that of the psychiatric hospital sample. A similar low rate of delirium was obtained in a study from Turkey, but this was attributed to the inability of clinicians to detect it (31). Unlike the general hospital, the predominant psychiatric disorders in the psychiatric hospital were schizophrenia/delusional disorder and bipolar affective disorder.

Although the more serious psychiatric cases were encountered in the psychiatric hospital, the general hospital offers a wider variety of minor psychiatric morbidity similar to the types encountered in the community⁶. These findings have a serious implication for medical education. By emphasizing C-L psychiatry, medical students will be exposed to a wide variety of psychiatric disorders similar to the type they will encounter in the primary care upon graduation³². The use of these two facilities should be seen as complementary, rather than as substitutes³³.

The observed high rate of minor psychiatric disorders in this sample, and the dearth of psychiatrists in this country, coupled with fact that it is an archipelago, make it necessary that generalists in the Fiji Islands are adequately trained in psychiatry. This will enable them to be better able to manage effectively a vast majority of psychiatric cases, and refer difficult ones to a psychiatrist. This will further enhance the quality of telemedicine (a

generalist seeking the opinion of a specialist through the telephone) that is sometimes practised and likely to be used more often in this country. It is a known fact that, psychiatric consultation support improves the generalist's diagnostic and therapeutic skills thereby enabling early identification and proper management of widespread mental disorders³⁴.

Managing the C-L psychiatric patients on their original beds of admission, which is the practice in this centre, has a lot of advantages. It enables the non-psychiatric doctors and nurses to participate in the care of the mentally ill, thereby enabling them to develop positive attitude towards psychiatry. It also enables the members of the general public, who are in greater contact with the general hospital than the psychiatric hospital, to be aware of the effectiveness of psychiatric management. This in turn will lead to a reduction in stigma associated with psychiatric disorders¹¹. Demonstrating the effectiveness of psychiatric treatment through C-L service will in fact support the advocacy for the establishment of a psychiatric unit in every general hospital in this country. The absence of C-L service in a majority of our general hospitals, at present, means that there are patients with unmet mental health needs³⁵.

When considered singly, obstetric complications ranked first, followed by cardiovascular disorders, autoimmune diseases and gynaecological disorders, apart from deliberate self-harm. The picture is not different from what is expected in a developing society that is influenced remarkably by western culture. The prevalence of infections is declining, while those of cardiovascular disorders such as hypertension, and autoimmune diseases such as rheumatoid arthritis are on the increase. The pattern is different from that of a similar study

conducted in Nigeria, where the predominant conditions were infections, cardiovascular diseases, neurological disorders and obstetric conditions, in this order¹⁴. Cardiovascular conditions, neurological disorders and other conditions managed by the internist constituted over two-fifth of the primary disorders in those referred to the C-L service. Similar high rates of referrals from internal medicine have been observed in Turkey and Nigeria^{14,31}. This observation further emphasized the need for the internist and the psychiatrist to collaborate in clinical practice and research in our local settings.

Over 60% of the cases seen on the C-L psychiatric service belonged to the 16-45 years age group. A similar finding was obtained in a study of this nature conducted in Nigeria¹⁴. The population structure of this country is pyramidal, with under-20-years at its base constituting about 50% of the entire population and the elderly at its

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apex³⁶. The finding clearly indicated that a majority of those affected belonged to the productive segment of the population. This may have an adverse impact on the labour force of the country.

Higher rate of females in this sample may be due to a number of possibilities. It may reflect the gender distribution in the overall population. It may be due to the fact that women are more vulnerable to depressive episode and anxiety-related disorders, which were the most common syndromes in this sample. Besides, it may reflect the pattern of help seeking behaviour of the two genders.

About one-third of the C-L psychiatric patients were cases of deliberate self-harm. This is less than 50% obtained in a similar sample in Kuwait³⁴, but higher than that of Thailand (22.4%)²³ or Nigerian (2.3%) cohort¹⁴. An early report from this country indicated that; a majority of patients with attempted suicide were females³⁸. This finding further affirms the susceptibility of women to attempted suicide and psychosocial morbidity. This calls for greater attention on women's mental health in this society, especially at the preventive level.

The preponderance of Indians in this sample may reflect their high vulnerability to psychosocial morbidity or a greater tendency to service utilization. Anecdotal experience in this setting has shown that Indian women have the tendency to somatize symptoms of psychological origin, and would therefore present more readily in the general hospital, rather than in the psychiatric hospital. The extent to which each of these factors influences the observed high rate of Indians in this sample will possibly be a subject of future investigations.

From the foregoing, it is evident that the most likely person to utilize the C-L service in this population is a young adult female Indian suffering from an internal medical condition, requiring inpatient care, complicated by depressive episode, which makes psychiatric referral necessary. The C-L and psychiatric hospital patients are different regarding age, gender, race and patterns of psychiatric morbidity. The emerging picture of C-L psychiatry in this country is that expected of a society in transition, from a traditional system to Western culture. It is hoped that this report will stimulate further interest on the influence of culture and technology on C-L psychiatry.

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Ngora Yubet era keburs

Translation: Like the core of a mangrove tree

*Meaning: Refers to a person of endurance or persistence.
A person who stays with his job or task for a long time.*

A saying from Palau