Original Article

Quality of psychiatric referral letters in a Nigerian tertiary hospital: a one-year clinical audit

Oluwabunmi Idera Nimat Buhari,[1] Ayodeji Saad Erubu,[2] Ibrahim Adewale Abdulsalam,[3] Jane Adebusola Ogunmodede,[1] Ayotunde Bolatito Omotoso[1]

[1]Department of Behavioural Sciences, Faculty of Clinical Sciences, University of Ilorin, Ilorin, Nigeria
[2]Department of Psychiatry, Afe Babalola University, Ado- Ekiti, Nigeria
[3]Department of Behavioural Sciences, University of Ilorin Teaching Hospital, Ilorin, Nigeria.

Abstract

Background: Effective referral communication is essential for safe and efficient psychiatric care. Inadequate referral information may delay diagnosis, compromise patient safety, and disrupt appropriate prioritization of care.

Aim: This study audited the completeness and overall quality of referral letters received at the in-patient unit of a teaching hospital in North-Central Nigeria.

Methods: A retrospective cross-sectional audit of 81 referral letters received between August 2024 and July 2025 was conducted. Referral letters were assessed using a ten-item structured checklist, informed by American Psychiatric Association (APA) and Royal College of Psychiatrists standards. Each item was scored as present or absent, generating a total score ranging from 0 to 10. Overall quality was categorized as poor (0–3), moderate (4–6), or good quality (7–10). Data were analyzed descriptively.

Results: Only 3.7% of referral letters met criteria for good quality. Total checklist scores ranged from 1-7 with mean score of 4.04 (SD=1.36). Although patient biodata (98.8%) and presenting complaints (96.3%0 were frequently documented, critical psychiatric information was largely absent. Mental state examination was recorded in only one letter (1.2%), while Past psychiatric history (18.5%) and psychosocial history (13.6%) were poorly documented. Most referrals originated from the Adult Emergency Medical Ward.

Conclusion: Psychiatric referral letters in this setting frequently lacked essential clinical information required for effective triage and management. Hospital-wide adoption of standardized referral templates, targeted clinician training, and routine audits may improve referral quality and enhance the efficiency of psychiatric care delivery.

Keywords: Psychiatric referral, quality improvement, referral quality, clinical audit

Address for correspondence: Dr. Ayodeji Saad Erubu, Department of Psychiatry, Afe Babalola University, Ado- Ekiti, Nigeria.
Email: erubua@abuad.edu.ng , ayoerubu@gmail.com
Phone: +2347030659980

Received: 24-04-2026, **Accepted:** 30-07-2026

Access this article online	
Quick Response Code:	**Website:** www.phmj.org.ng
	DOI: https://doi.org/10.60787/phmj.v20i2.286

How to cite this article: Buhari OIN, Erubu AS, Abdulsalam IA, Ogunmodede JA, Omotoso AB. Quality of psychiatric referral letters in a Nigerian tertiary hospital: a one-year clinical audit. Port Harcourt Med J 2026;20(2):147-154.

INTRODUCTION

High-quality referral letters are a critical component of communication between healthcare providers and psychiatric services. They often serve as the first point of information exchange between referring clinicians and mental health specialists, guiding triage, prioritization, and initial management decisions. Standard psychiatric texts emphasize that an adequate referral should include patient identifiers, presenting complaints, relevant psychiatric and medical

history, risk assessment, psychosocial background, prior treatments, and a clear reason for referral.[1-3] The importance of referral quality is further highlighted by Goldberg and Huxley's model of pathways to psychiatric care, which proposes that access to specialist mental health services is influenced by a series of filters through which individuals progress from the community to primary care and ultimately to specialist psychiatric services. Poor communication at the referral stage may impede movement through these filters and delay access to appropriate care.[4] The World Health Organization [5] also underscores the need for structured referral pathways, especially in low- and middle-income countries (LMICs), to optimize scarce specialist resources.

Despite these standards, the quality of referral letters to psychiatric services is often suboptimal. International audits have consistently reported missing or inadequate clinical details, leading to delays, duplication of investigations, and compromised continuity of care. These challenges are particularly significant in psychiatry, where comprehensive history, risk information, and psychosocial context are critical for accurate assessment and treatment planning. Evidence from Nigeria suggests that referral letters to psychiatric departments frequently lack essential details. Esan and Oladele (2016), in an audit at University College Hospital, Ibadan, found that more than 80% of referrals omitted psychosocial history, medication history, risk assessment, and prior management details.[6] Similarly, Oluwole et al. (2021) reported that a substantial proportion of referral letters to Ekiti State University Teaching Hospital lacked complete biodata, omitted reasons for referral, and rarely stated expectations of the psychiatrist.[7] More recently, Oriji et al (2025) observed that a substantial proportion of consultation-liaison referrals to psychiatry at Nnamdi Azikiwe University Teaching Hospital lacked information on ongoing treatment and urgency.[8] While previous Nigerian studies have identified deficiencies in the South-West and South-East, there is a paucity of data from the North-Central region. Furthermore, comprehensive audits focusing specifically on inpatient referral across all hospital departments within a single tertiary institution are limited.

In low- and middle-income (LMICs) settings such as Nigeria, these deficiencies in quality of referrals are often attributed to limited formal training, the absence of standardized templates for referral, heavy clinical workloads and persistent stigma surrounding mental health. Given the high mental health treatment gap and limited psychiatric resources in the country, poor-quality referrals risk exacerbating delays in care and inefficient use of specialist services.

This study, therefore, aimed to systematically assess and analyze the completeness of content and quality of referral letters received at the psychiatric department of a teaching hospital in north-central Nigeria, with a view to identifying gaps, informing training, and supporting the development of standardized referral practices.

MATERIALS AND METHOD

This clinical audit employed a retrospective, cross-sectional descriptive design and was conducted in the Department of Behavioural Sciences of a tertiary health facility located in North-Central Nigeria.

The audit population comprised all inpatient and emergency referral letters requesting psychiatric evaluation received by the department over a 12-month period, from August 2024 to July 2025. Inclusion criteria were referral letters originating from inpatient wards and the emergency unit. Outpatient referrals and duplicate referral letters were excluded.

The quality of referral letters was assessed using a structured ten-item checklist developed by the authors. The checklist was informed by core components recommended in international psychiatric referral guidelines [1,2] and adapted from items used in a previous, similar clinical audit conducted in Nigeria.[6] The selected items represent the minimum information required for safe and effective triage and initial psychiatric assessment. Face validity of the checklist was established

through independent review by two consultant psychiatrists within the department with good inter-rater reliability although no comprehensive psychometric validation.

The checklist assessed the presence of the following items: patient biodata, presenting complaints, clarity of referral information, mental state at presentation, severity and complications of symptoms, past psychiatric history, past medical and surgical history, relevant psychosocial history, provisional diagnosis, and initial management prior to referral. Each item was scored as present (1) or absent (0) using binary scoring, yielding a maximum possible score of 10. Total scores were categorised as poor (0–3), moderate (4–6), or good (7–10) quality.

Two researchers independently reviewed all eligible referral letters using the checklist. Inter-rater reliability was assessed using Cohen's kappa coefficient ($\kappa = 0.80$), indicating substantial agreement. Any scoring discrepancies were resolved through discussion and consensus.

Data were entered into and analysed using Microsoft Excel 2021 (Microsoft Corporation, Redmond, WA, USA). Descriptive statistics, including frequencies, percentages, means and standard deviations. A descriptive comparison was conducted between referrals originating from the adult emergency ward and those from all other wards combined to explore differences in referral practices by source.

Ethical considerations

Ethical clearance for this study was gotten from Health Research Ethics Committee (HREC) of University of Ilorin Teaching Hospital with protocol number: ERC PIN/2026/12/1590 and approval number: ERC PAN/2026/02/0592. All patient identifiers were anonymised, and the audit was conducted in accordance with principles of medical ethics, guided by the Declaration of Helsinki as revised in 2013.[9]

RESULTS

A total of 81 referral letters met the inclusion criteria and were analyzed. Table 1 shows the demographic characteristics of the referred patients. Most referrals involved young and middle-aged adults, with the highest proportion in the 21-30 years age group (29.6%). Females constituted a slight majority of referrals (55.6%).

Table 2 summarizes the completeness of the ten checklist items across referral letters. The most consistently documented items were biodata (98.8%), presenting complaints (96.3%), and initial management prior to referral (96.3%).

In contrast, documentation of core psychiatric elements was poor. The mental state examination at presentation was documented in only one letter (1.2%). Similarly, the severity and complications of the patient's symptoms were noted in only five (6.2%) of letters. Key historical information, such as the past psychiatric history (18.5%), past medical and surgical history (16.1%), and relevant psychosocial history (13.6%), was infrequently documented.

The total checklist scores ranged from 1 to 7 out of a possible 10, with a mean of 4.04 (SD = 1.36). As shown in Table 3, the majority of referrals (51, 63.0%) were of moderate quality (scoring 4-6), while a significant proportion (27, 33.3%) were classified as poor quality (scoring 0-3). Only a minimal number (3, 3.7%) achieved a 'good' quality score (7-10).

The majority of referrals originated from the Adult Emergency Medical Ward (59, 72.8%). No other ward contributed more than 9% of the total referrals (Table 4).

No marked differences in referral quality were observed between emergency and non-emergency referrals.

Table 1: Demographic characteristics of patients referred for psychiatric evaluation (N=81)

Variable	Frequency (%)
Age group (years)	
≤ 20	12(14.8)
21-30	24 (29.6)
31 -40	15 (18.5)
41-50	15 (18.5)
51-60	7 (8.6)
≥ 61	8 (9.9)
Sex	
Male	36 (44.4)
Female	45 (55.6)

Note: age and sex were extracted from referral letters where documented.

Table 2: Completeness of referral letter using 10-item checklist (N= 81)

Checklist	Present N (%)	Absent N (%)
Biodata	80 (98.8%)	1 (1.2%)
Presenting Complaints	78 (96.3%)	3 (3.7%)
Clarity of information	70 (86.4%)	11 (13.6%)
Mental State Examination at presentation	1 (1.2%)	80 (98.8%)
Severity & Complications	5 (6.2%)	76 (93.8%)
Past Psychiatric History	15 (18.5%)	66 (81.5%)
Past Medical and Surgical History	13 (16.1%)	68 (83.9%)
Relevant Psychosocial History	11 (13.6%)	70 (86.4%)
Provisional Diagnosis	40 (49.4%)	41 (50.6%)
Initial Management	78 (96.3%)	3 (3.7%)

Note: each item was scored as present or absent based on documentation in the referral letter.

Table 3: Overall quality of psychiatric referral letters based on checklist scores

Quality Category	Number of referrals	Percentages (%)
Poor (0-3)	27	33.3
Moderate (4-6)	51	63.0
Good (7-10)	3	3.7
Total (Overall)	81	100
Mean score ± SD	4.04 ± 1.36	
Score Range	1-7	

Note: Quality categories were defined as Poor (0-3), Moderate (4-6) or Good (7-10) based on total checklist scores. The overall mean score was 4.04 (standard deviation, SD= 1.36), with scores ranging from 1-7.

Table 4: Source of psychiatric referrals by hospital wards

Referring Ward	Number of referrals	Percentage (%)
Adult Emergency Medical ward	59	72.8
Adult Emergency Surgical ward	2	2.5
Adult Medical Ward	7	8.6
Adult Surgical Ward	4	4.9
Paediatric Medical ward	2	2.5
Paediatric Surgical ward	1	1.2
Obstetric and Gynaecological ward	3	3.7
Trauma Centre	1	1.2
Intensive Care Unit	1	1.2
Ear Nose and Throat ward	1	1.2

Table 5: Descriptive comparison of psychiatric referral quality by source of referral

Referral source	Number of referrals (%)	Dominant quality category
Adult emergency medical ward	59 (72.8)	Moderate
All other wards	22 (27.2)	Moderate

Note: This comparison is descriptive and intended to highlight patterns in referral practices rather than to infer statistical differences between groups.

DISCUSSION

This clinical audit assessed the quality of referral letters received at the Department of Behavioural Sciences of a tertiary health facility over a one-year period. It revealed substantial deficiencies in the quality of psychiatric referral letters at the teaching hospital, with the majority lacking essential clinical information required for effective triage and management despite originating from a tertiary healthcare setting where specialist services are readily available. These findings are consistent with previous audits from Nigerian and international studies that have documented incomplete communication between medical and psychiatric services. [1,2,6-8]

The pattern of documentation observed in this audit is similar to that observed in earlier studies. While basic demographics and presenting complaints were reliably recorded, core psychiatric elements were consistently omitted. Notably, mental state examination was almost entirely absent, appearing in only 1.2% of referral letters, while past psychiatric (18.5%) and psychosocial history (13.6%) were poorly documented, comparable to the findings by Esan & Oladele [6] and Oluwole et al.[7] These observed deficiencies suggest the presence of broader system-level challenges rather than isolated lapses in individual clinical practice within the Nigerian healthcare context.

The persistent omission of psychiatric-specific information, despite adequate documentation of basic demographics, suggests that the underlying issue extends beyond mere forgetfulness. This interpretation is also consistent with the contemporary relevance of the Goldberg-Huxley model of pathways to psychiatric care. In their recent systematic review, Huxley et al. reaffirmed that barriers at different levels of the care pathway, including deficiencies in communication and referral processes, continue to influence timely access to specialist mental health services across diverse healthcare systems.[10] These findings support the view that improving the quality of referral communication is an important component of strengthening access to psychiatric care.[10]

It may likely reflect a combination of factors prevalent in many LMIC (low- and middle-income countries) settings: a lack of formal training in psychiatric history taking and referral writing among non-psychiatry clinicians, extremely high clinical workloads that prioritize brevity over comprehensiveness, the absence of a mandated standardized template, and potentially persistent stigma, which may lead referring clinicians to undervalue the importance of psychosocial and mental state details. The near-total absence of mental state documentation is particularly indicative of a gap in understanding what constitutes essential information for a psychiatric referral.

The distribution of checklist scores further reinforces this interpretation. The total scores clustered around the lower end of the moderate quality range, with a mean score of 4.04 (SD = 1.36) and a restricted observed range of 1-7 despite a maximum possible score of 10. This pattern indicates that most referrals contained only minimal clinical information and often functioned primarily as requests for psychiatric consultation rather than as structured clinical handovers, a trend previously described in Nigerian and other low-resourced settings. [1, 2, 6, 7 ,11]

These deficiencies have important clinical implications. The absence of documented mental state examination and assessment of symptom severity, as seen in over 93% of our referrals, significantly compromises the

receiving psychiatrist's ability to perform reliable triage and prioritize care. This finding directly supports the evidence from Nymoen et al.,[12] which established a link between poor referral quality and unreliable patient prioritization, delaying access to timely specialized care.[12] In acute and emergency contexts, incomplete referral information may increase the risk of delayed intervention, misclassification of urgency and inefficient use of limited psychiatric resources.

Furthermore, inadequate documentation of past psychiatric, medical and psychosocial histories obliges psychiatrists to expend additional time obtaining basic clinical information, thereby increasing workload and delaying assessment. This challenge has been highlighted in liaison psychiatry settings by Loveday et al.,[13] who demonstrated that poor referral information contributes substantially to service inefficiency. In the present study, the predominance of referrals from adult emergency medical ward underscores the importance of effective communication at the medical–psychiatric interface. Although no clear qualitative advantage was observed in referrals originating from non-emergency wards, the high volume of emergency referrals amplifies the clinical impact of poor documentation, as incomplete information in this context may directly affect triage decisions and patient safety. The absence of consistent provisional diagnoses and risk-related information further supports concerns that referrals often function as simple consultation requests rather than comprehensive clinical handovers, a problem previously noted in literature.[11]

The findings from the audit support the implementation of a structured, multilevel intervention to improve referral quality. The identified deficiencies mirror broader systemic challenges in low-resources settings, where ineffective referral pathways are a documented barrier to mental health service delivery.[14] To address this, the development and mandatory use of a standardized referral template are strongly indicated. As demonstrated by Hartveit et al.,[15] such templates can directly rectify common omissions by mandating core clinical items such as mental state findings and risk assessment.

This aligns with the WHO's emphasis on strengthening care coordination and community-based networks to improve service quality and accessibility. [16, 17]

Consequently, our recommendation for a standardized electronic or paper referral template is not merely a local fix but a targeted response to a known systemic weakness. Evidence such as that from Hartveit et al.,[15] confirms that a structured template significantly improves the completeness of clinical handovers. Implementing this tool is a practical step towards the WHO's strategic objective of building a coordinated community-based network of care, which depends on reliable communication between providers.[16,18] Furthermore, to ensure the template is used effectively, brief targeted training sessions for high-referral departments are crucial. Finally, establishing a routine audit and feedback mechanism**,** as supported by implementation science, creates a cycle of continuous improvement and accountability, helping to institutionalize high-quality referral practices.[14]

The strengths of this audit include its structured and comprehensive assessment of referral letter content using a checklist informed by international standards, as well as the inclusion of all eligible inpatient referrals during the study period. However, the study is limited by its retrospective, single-center design, which may limit the generalizability of findings to other settings. Furthermore, the study assessed the documented content but could not assess the accuracy of the information provided or the underlying clinical reasoning of the referring clinician. Additionally, the study did not examine patient outcomes or the direct impact of referral quality on clinical decision making, which may be an important focus for future research.

As a baseline clinical audit, the next phase will focus on completing the audit cycle through targeted quality improvement interventions. These will include dissemination of findings, introduction of a standardized psychiatric

referral template, and brief orientation sessions for clinicians in high-referral units, particularly the adult emergency medical ward. A re-audit will be conducted after 12 months using the same checklist to assess changes in referral quality and documentation of key psychiatric elements, thereby evaluating the impact of these interventions.

This study has some limitations. As a single-centre retrospective audit, the findings may not be generalisable to other healthcare settings. The locally developed checklist, although informed by international guidelines, adapted from previous studies, and demonstrating substantial inter-rater reliability, underwent only face validation and was not subjected to comprehensive psychometric validation.

CONCLUSION

This audit demonstrates the quality of psychiatric referral letters to a Nigerian tertiary hospital is largely suboptimal, with major omissions in essential clinical information required for effective triage and management. Although the adult emergency medical ward accounted for the highest volume of referrals, deficiencies in referrals and referral content were observed across all clinical departments, indicating a hospital-wide systemic challenge rather than an issue confined to specific wards. These gaps in referral communication have important implications for patient safety, clinician workload, and the efficient use of limited psychiatric resources. We therefore recommend the urgent development and implementation of a standardized referral protocol, coupled with targeted clinician education and a regular audit cycle to transform referral letters into effective tools for clinician handover and improve the quality of care at the medical-psychiatric interface.

DISCLAIMER

The views and opinions expressed in this article are those of the authors. They do not necessarily reflect the official position of any affiliated institution, agency, or that of the publisher. The authors are responsible for this article's results, findings, and content.

Financial support and sponsorship:

Nil

Conflict of interest:

There are no conflicts of interest.

REFERENCES

1. Silverman JJ, Galanter M, Jackson-Triche M, Jacobs DG, Lomax JW 2nd, Riba MB, et al. The American Psychiatric Association Practice Guidelines for the psychiatric evaluation of adults. Am J Psychiatry 2015;172(8):798-802.
2. Royal College of Psychiatrists. Good psychiatric practice. 3rd ed. College Report CR154. London: Royal College of Psychiatrists, 2009.
3. Owens DC, McKenna PJ, Davenport R. Clinical assessment. In: Johnstone EC, Owens DC, Lawrie SM, McIntosh AM, Sharpe M, editors. Companion to Psychiatric Studies. 8th ed. Edinburgh: Churchill Livingstone Elsevier, 2010; 199–226.
4. Goldberg D, Huxley P. Common mental disorders: a bio-social model. London: Tavistock/Routledge, 1992.
5. World Health Organization. Framework on Integrated, People-centred Health Services: Report by the Secretariat. Geneva: World Health Organization; 2016. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf. Accessed December 10th, 2025.
6. Esan O, Oladele O. Referral letters to the psychiatrist in Nigeria: is communication adequate? Afr Health Sci 2016;16(4):1023-1026.
7. Oluwole LO, Obadejii A, Dada MU. Doling out too little for priority sake: an audit of referral letters to a tertiary psychiatric unit in Nigeria. Niger Health J 2021;20(4):143–149.
8. Oriji SO, Onu JU, Nwiyi OK, Chimbo C, Erohubie PO, Anozie IG, et al. Quality of consultation-liaison referrals to the psychiatry department in a Nigerian teaching hospital: a retrospective study. Niger Postgrad Med J 2025;32(2):92-96.

9. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. JAMA 2013;310(20):2191–2194.
10. Huxley P, Krayer A, Poole R, Gromadzka A, Jie DL, Nafees S. The Goldberg-Huxley model of the pathway to psychiatric care: 21st-century systematic review. BJPsych Open 2023;9(4):e114.
11. Burns T, Bale R. Establishing a mental health liaison attachment with primary care. Adv Psychiatr Treat 1997; 3(4): 219-224.
12. Nymoen M, Biringer E, Hetlevik Ø, Thorsen O, Assmus J, Hartveit M. The impact of referral letter quality on timely access to specialised mental health care: a quantitative study of the reliability of patient triage. BMC Health Serv Res 2022;22(1):735.
13. Loveday WH, Panagiotopoulou L, Dineva D, Pita AA, Eltuhamy Y, Sabir A, et al. Improving referrals to community mental health services in the liaison setting. BMJ Open Quality. 2022;11:e001651.
14. Qureshi O, Endale T, Ryan G, Miguel-Esponda G, Iyer SN, Eaton J, et al. Barriers and drivers to service delivery in global mental health projects. Int J Ment Health Syst 2021;15(1):14.
15. Hartveit M, Thorsen O, Biringer E, Vanhaecht K, Carlsen B, Aslaksen A. Recommended content of referral letters from general practitioners to specialised mental health care: a qualitative multi-perspective study. BMC Health Serv Res 2013;13:280.
16. World Health Organization. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health gap action programme (mhGAP). Geneva: World Health Organization, 2010.
17. World Health Organization. Mental health. Geneva: World Health Organization, 2025. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response. Accessed January 12, 2026.
18. Funk M, Drew N, Cole C, Moro MF. New WHO guidance on mental health and well-being across government sectors. World Psychiatry 2026;25(1):147–148.