Factors associated to urgent referral in a mental health center

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Factores asociados a la derivación urgente en un centro de salud mental

Summary

Introduction. *In this paper we analyze the factors related with the urgent referral.*

Method. *We analyze a sample of 718 patients who were seen for an initial medical visit during a one year period in a community mental health center (418 of whom were urgent patients and 300 programmed patients). Variables associated to the referral process, clinical variables and social adjustment are studied.*

Results and conclusions. *The urgent medical visit is associated to clinical importance, to people previously seen in the health system, to initiative by others and not by the patient, to diseases that cause dysfunction in the sociofamiliar environment, and to the subjective loneliness feeling. The data show very little agreement between the clinician in the mental health center and referral doctor evaluation.*

Key words: *Demand. Mental health. Urgency. Clinical characteristics. Referral process. Social adjustment.*

Resumen

Introducción. *En el presente trabajo nos planteamos como objetivos analizar los factores asociados con la demanda de consulta urgente ambulatoria.*

Método. *Se analiza una muestra de 718 pacientes atendidos en primera consulta en el período de un año en un centro de salud mental (418 como urgentes y 300 como programados). Se analizan variables asociadas al proceso de derivación, variables clínicas y el apoyo psicosocial.*

Resultados y conclusiones. *La consulta urgente se asocia a la gravedad clínica, a sujetos atendidos previamente en la red asistencial, a que la iniciativa parte de otros y no del propio paciente, a patologías que causan disfunción en el medio sociofamiliar y a la vivencia subjetiva de soledad. Los datos muestran poco acuerdo entre la valoración del clínico en el centro de salud mental y la del médico derivante.*

Palabras clave: *Demanda. Salud mental. Urgencia. Proceso de derivación. Características clínicas. Apoyo social.*

INTRODUCTION

The implementation of the mental health public system has led to its consolidation and to an increase in demand while the human resources remain practically invariable[1-4]. Parallelly to the increased demand, psychiatric emergencies are also growing, thus producing a distortion in the service planning[5,6]. The existing bibliography on the study of urgent demand in mental health centers (MHC) is scarce; most of the literature published on emergencies refers to the hospital context[7-9].

Research on demand by mental disease, and especially of the emergency, is complicated because there are many manifest or hidden factors that make it difficult to evaluate health care. Besides, as is shown in some studies[7], emergency care demands indirectly reflect the capacity of the health care system and social services to resolve the mental health problems, allowing for greater programming of the care.

There are some specific studies on emergencies seen in a mental health center[10,11] that indicate that these are more frequent in the out-patient context than in hospital emergencies, that there is a high percentage of inadequate indications for emergency care by the family physician, that the patients themselves come to the reference centers when they feel bad, that the emergencies seen in the MHC are practically not referred for hospital admission, and that there is no difference in regards to the symptoms or seriousness between preferential and programmed patients.

One of the aspects studied most in the process of referral to mental health are those referrals made from Primary Health Care and the variables that influence them[12-16]: the nature of the patients, training of the family physicians, seriousness of psychiatric symptoms, patient handling difficulty, high health care pressure. In general, the health care pathway to psychiatric services is domi-

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nated by the Primary Health Care physician[17-18]. Another one of the elements present in the literature is the study on referral reports used to facilitate communication between the clinician who refers the patient and the specialized service[19,20]. The reports express the reason for the referral, some information that can orient the specialist or diagnostic hypothesis and, sometimes, the treatment prescribed. Its fulfillment is studied as the expression of the relationships and functioning level between the first and second mental disease care level.

Psychotic symptoms, suicidal ideation, lack of control of impulses and behaviors related with toxic consumption are among the most frequent reasons for the visit to the hospital emergency service[21-24]. Sometimes, it may not be so much the disruptive behaviors that arise from these symptoms but rather the absence of social support that justifies the need for an urgent intervention[25]. The bibliogra-phy indicates the experience of loneliness as a factor that favors the request for a visit and the search for formal support networks because informal ones are not available[26-28]. Social withdrawal is considered a relevant factor associated to psychiatric morbidity and to health care demand[29-31].

We consider that more research must be carried out on the variables that lead to urgent medical visits in order to improve response to this type of demand that affects the organization of the services and health care quality since it requires rapid and difficult to program responses. The present study complements two previous ones[32-33] in which we study the evolution of the demand received in the MHC-Sur of Seville based on several variables. In them, we report on an increase in emergency visits, in our population, inverting the programmed care/emergency care ratio. Now we analyze the factors associated to the urgent referral in relationship with the referral process, the clinical characteristics of the cases and the social support perceived by the patient.

METHOD

The sample is made up of 718 subjects over 18 years of age who came to the Seville-Sur Mental Health Center, distributed into two groups based on the referral form (table 1). A total of 418 subjects made up the group we call «urgent» that includes both emergency as well as preferential referrals; the programmed group is made up of 300 subjects with appointments according to the waiting list. The general characteristics of the sample were described in a previous article[33], where we statistically analyze the differences and similarities of both groups in regards to the sociodemographic variables and those related with the referral characteristics. The present analysis proposes to complete the previous one by including another series of variables that may play a role in whether the demand for help by psychopathology acquires an urgent character.

TABLE 1. Distribution of the groups

Emergency	418 (58%)
Programmed	300 (42%)
Total	718 (100%)

We divide the variables of this study into three groups. The first includes those aspects prior to the visit such as: who accompanies the patient, if the patient had received treatment prior to the visit and with whom, if the referral physician indicated drug treatment, the existence of some somatic disease and the reasons of the family physician to refer those patients coming from Primary Health Care. A second group includes data supplied by the MHC clinicians. They are: clinical diagnosis that the patient receives after the first interview, assessment of its clinical seriousness, degree of agreement with the referral pathway used and the orientation of treatment given to the case. The third group has data supplied by the patient such as the subjective assessment made of what is happening to him or her and questions on social support perceived (if the patient feels alone, if he/she has anyone to go to and if he/she feels understood and supported).

Given that the variables are qualitative, we used the Chi squared test for statistics.

RESULTS

We differentiate three sections in the analysis of the results: *a*) variables related with the factors associated to referral; *b*) variables related with the clinical characteristics, and *c*) variables related with the patient (subjective opinion on psychosocial support and condition).

Regarding the factors associated to referral

In this section (tables 2 and 3), we first observe that most of the patients who come to the MHC are accompanied, although the significant differences indicate that those who are referred to the emergency service are generally those who are accompanied by some family member while the percentage of the patients who come to programmed appointment alone or accompanied is similar. The companions are mostly family in both groups.

Somewhat more than half of those consulting are under treatment with some professional before the mental health visit. The statistical significance indicates that the patients who are being treated with a psychiatrist are those who generally come to the emergency service while the programmed visits were generally seen by the Primary Health Care physician.

The relationship between type of care and if the referring physician did or did not indicate drug treatment prior to the referral is not significant. Regarding whether the patients received treatment for any somatic disease, we have observed significant differences between urgent and programmed patients, with a greater propor-

TABLE 2. Factors associated to the referral

	Emergencies	*Programmed*	*Significance*
Who the patiens comes with to the MHC			
Accompanied by family	253 (61%)	130 (44%)	$Chi^2 = 20.978$
Acompanied by others	15 (3%)	13 (4%)	p = 0.000
Comes alone	150 (36%)	157 (52%)	Significant
The patient was in treatment befor e			
PHC physician	129 (31%)	124 (41%)	$Chi^2 = 13.933$
Psychiatrist	71 (17%)	28 (9%)	p = 0.008
Psychologist	2 (0.5%)	3 (1%)	Significant
Others	17 (4%)	11 (4%)	
Was not in treatment	199 (47.5%)	134 (45%)	
The referring physician indicated tr eatment			
Yes	232 (55%)	157 (52%)	$Chi^2 = 0.707$
No	186 (45%)	143 (48%)	p = 0.401
			Not significant
Tr eatment is made for somatic disease			
Yes	151 (36%)	132 (44%)	$Chi^2 = 4.536$
No	267 (64%)	168 (56%)	p = 0.033
			Significant

TABLE 3. Report on referral

	Emergencies	*Programmed*	*Significance*
Clinical seriousness			
Yes	99 (36%)	15 (6%)	$Chi^2 = 65.142$
No	174 (64%)	221 (94%)	p = 0.000
			Significant
No improvement with treatment			
Yes	65 (24%)	65 (28%)	$Chi^2 = 0.927$
No	208 (76%)	171 (72%)	p = 0.336
			Not significant
Family pressur e			
Yes	30 (11%)	26 (11%)	$Chi^2 = 0.000$
No	243 (89%)	210 (89%)	p = 0.992
			Significant
Patient r equest			
Yes	82 (30%)	114 (48%)	$Chi^2 = 17.84$
No	191 (70%)	122 (52%)	p = 0.000
			Significant
Indication of another specialist			
Yes	42 (15%)	27 (11%)	$Chi^2 = 1.68$
No	231 (85%)	209 (89%)	p = 0.195
			Not significant
Care pressur e			
Yes	2 (1%)	10 (4%)	$Chi^2 = 1.68$
No	271 (99%)	226 (96%)	p = 0.009
			Significant
Lack of training			
Yes	13 (5%)	20 (8%)	$Chi^2 = 2.878$
No	260 (95%)	216 (92%)	p = 0.09
			Not significant
Report for administration			
Yes	4 (12%)	8 (3%)	$Chi^2 = 2$ Yes 037
No	269 (98%)	228 (97%)	p = 0.154 Not sig.

tion of urgent patients having no somatic disease (in a previous article[33], we see that this group is mainly made up of young persons).

We can only analyze the reasons for referral of the family physicians since this is the only group that had the referral protocol to MHC that asked them to specify the different reasons justifying their decision to refer the patient to the specialized center (table 3). It was not possible for the remaining referring professionals to have this protocol. The data gathering the basis of the medical visit request corresponds to 509 patients (86% of all the referrals by the Primary Health Care physician). The reasons that justify the request for a visit to the MHC included: clinical seriousness, no improvement with the treatment, family pressure, patient request, lack of training in mental health, indication by other specialist and report for administration. Only for clinical seriousness is statistically significant, this being the main reason for the referral to the Emergency Service. Patient request, mostly for programmed visit, is also significant. Health care pressure is hardly mentioned as a factor influencing referral; it does not seem to be one of the explicit causes that justify the emergencies.

Regarding the clinical characteristics

In the first place, we are going to analyze the clinical diagnosis (table 4) received in both care groups, following the ICD-10 classification (organized in 8 diagnostic groups and «in study» and «without disease» codes), which provides statistical significance. The most frequent diagnoses in both groups are neurotic disorders followed by affective ones. The high number of persons referred with addictive disorders calls our attention, because this disease is not seen in the MHC-Sur. Psychotic disorders are referred, to a greater degree, through the non-programmed pathway as occurs in the addictive disorders.

If we observe the assessment made by the MHC clinician on the clinical seriousness of the patient, the lower frequencies correspond to «no disorder» and «seriously ill» categories, the latter being slightly greater among the emergencies. The proportions are reversed for the categories «mildly ill» (33% in emergencies and 55% in the programmed visits) and «moderately ill» (58 % in the emergencies and 36% in the programmed visits).

The relationship between type of care and the decision made by the MHC physician after the first interview

TABLE 4. Assesment of the clinician

	Emergencies	*Programmed*	*Significance*
Diagnosis			
Without disease	11 (2.6%)	11 (3.4%)	$Chi^2 = 41.663$
Organic d.	1 (0.2%)	2 (0.6%)	p = 0.000
Addictions	29 (7%)	12 (4%)	Significant
Psychotic d.	39 (10%)	7 (2.4%)	
Affective d.	115 (27%)	55 (18%)	
Neurotic d.	177 (42%)	162 (54%)	
Impulse d.	8 (2%)	6 (2%)	
Personality d.	21 (5%)	14 (5%)	
Mental retardation	4 (1%)	2 (0.6%)	
Under study	13 (3.2%)	29 (10%)	
Clinical impression			
No disorder	18 (4%)	22 (7%)	$Chi^2 = 45.998$
Mildly ill	138 (33%)	165 (55%)	p = 0.000
Moderately ill	241 (58%)	109 (36%)	Significant
Seriously ill	21 (5%)	4 (1%)	
Health care decision			
MHC	261 (62%)	142 (48%)	$Chi^2 = 21.926$
Mental Health Unit	1 (0.2%)	1 (0.3%)	p = 0.000
Primary Health Care	108 (25.8%)	110 (36.7%)	Significant
Others	31 (8%)	19 (6%)	
Not necessary	17 (4%)	28 (9%)	
Appropriateness of demand			
Yes	206 (49%)	226 (75%)	$Chi^2 = 49.456$
No	212 (51%)	74 (25%)	p = 0.000
			Significant

TABLE 5. Assesment of the patient

	Emergency	*Programmed*	*Significance*
Intensity problem			
Mild	64 (15%)	71 (24%)	$Chi^2 = 20.10$
Moderate	170 (41%)	144 (48%)	p = 0.000
Serious	184 (44%)	85 (28%)	Significant
The patient feels that he/she is alone			
Yes	280 (67%)	174 (58%)	$Chi^2 = 6.065$
No	138 (33%)	126 (42%)	p = 0.000
			Significant
The patient has someone to go to			
Yes	303 (72%)	212 (71%)	$Chi^2 = 0.286$
No	115 (28%)	88 (29%)	p = 0.543
			Not significant
The patient feels that he/se is understood and supportted			
Yes	240 (57%)	180 (60%)	$Chi^2 = 0.48$
No	178 (43%)	120 (40%)	p = 0.488
			Not significant

in the center is significant. There is an important percentage of patients in which discharge or referral to another service is decided after the first visit. Most of them are referred to Primary Health Care (25.8 % in emergencies and 36.7% in the programmed visits). Only two patients received an indication of hospital admission in the Mental Health Unit. However, the greatest percentage corresponded to patients who were following treatment in the MHC, especially the urgent referrals (62%).

There is significance between the independent variable and adequacy of the demand character; the greatest percentage of adequate referral corresponds to programmed visits (75%), there being a greater margin of disagreement in the emergency referrals.

Regarding the subjective opinion of the patient and social support

We include the data reported the patient in this group (table 5). We investigate the patient's subjective assessment on what occurs as well as his/her perception of social support received (examined through three questions). Thus, we observe that 44% of the patients who come through the emergency route assess their problem as «serious» compared to 28 % of the programmed visits. While the moderate experience is similar in both groups, assessment of mild predominates in the programmed group; it stands out that 15% of the emergency patients consider their problem as having «mild» intensity.

Regarding the examination of social support, we observe that there is a greater proportion of emergency referred subjects who state they feel alone (67%). On the other hand, approximately one third of the patients of each group report having someone to go to and almost half of the total sample feels understood and supported.

DISCUSSION

Although mental health emergencies must be given a place in health care, they break the continuity and order of an outpatient service. It is necessary to know their characteristics in order to be able to act adequately on them. Studying the sociodemographic, psychopathological factors and the social support of those consulting as well as the characteristics associated to the referral and the case assessment by the MHC professionals, we aim to identify which variables are involved in the emergency referral to outpatient clinics in mental health. This allows us to obtain references for a possible ordering and intervention of demands in MHC.

In an initial article, we discussed the sociodemographic variables, the most common characteristics of the emergencies being represented by young men who live with their origin family, in which the initiative for the visit comes from the family and who have no previous history of MHC; psychiatric hospital emergencies make

up the first contact with the health care service, from which the patients are referred to MHC.

Regarding the factors associated to the referral, the analysis of the results of this article show us that more than half of the subjects who consult via emergencies pathway were receiving drug treatment by a health care professional, mainly by their family physician, or by a psychiatrist (in general it was the hospital emergency service psychiatrist). This information indicates, on the one hand, the high percentage of emergency visits coming from hospital emergencies and, on the other, that the emergency visit in the MHC is often not the first intervention made on the psychopathological symptoms of the subject, which speaks for a first failure in the previous health care levels.

In the bibliography reviewed[12], clinical seriousness, insufficient knowledge and health care pressure are mentioned among the most important reasons proposed by the Primary Health Care physicians for referring patients to the specialized mental health service. It surprises us that only clinical seriousness has a considerable frequency in our study while the latter two causes are hardly specified by the physicians to justify their referral, either urgent or programmed. Clinical seriousness is one of the most potent variables that justifies the decision for an urgent visit versus a programmed one[24]. The request of the patient is more representative among the programmed patients, which agrees with the data that the initiative in emergencies comes from others and not from the patient him or herself[33]. We could consider that disruptive behaviors could be behind these emergencies[34] or that the patient has little opinion or says little on the care of his/her malaise. The options «lack of improvement with the treatment» and «lack of training», so scarcely mentioned by the physicians, could tell us that their level of knowledge on mental disorders has been increasing while the care of mental patients has been integrated into the health care system.

If we consider the clinical diagnoses, we find, in the first place, that the diseases mostly represented in the emergencies versus the programmed appointments are affective disorders, psychotic disorders and addictions. The percentage of addictive disorders is quite high, considering that the MHC-Sur does not see this type of disease. The problems caused by drug consumption nourishes the hospital emergencies in a large part[21,34,35] and this seems to also be generalized in the Primary Health Care visits, demands that can go beyond the resources of the family physician who believes that the MHC will give a faster and more specific response to the urgent demand of this type of patient.

Depressive disease is also very present in emergencies; it is known that epidemiology alerts about the increase of this disorder, that can have a high risk for the patient if suicidal ideation exists. Furthermore, severe depressive symptoms causes great anxiety in the family setting surrounding the patient[24].

Psychotic pictures are mainly seen through the emergency route, something that could be consider as normal, since psychotic symptoms either appear abruptly, causing great alarm in the sociofamilial setting or if their establishment is insidious, the lack of awareness of disease, present in many of these cases, may require the family and primary health care physician to consider the emergency service as the only option of health care contact.

Both addictions as well as psychosis are psychopathological pictures that are seen in the health care services with a certain frequency accompanied by behavior disorders[34,36,37]. Equally, the family physicians point to drug addicts and psychotics as patients who cause them more difficulty and tension[12]. In these two groups of patients, we wonder where the demand and alarm come from, possibly from the sociofamilial setting and from the institutions and not from the patient.

Jointly analyzing the data referring to clinical impression, health care decision and appropriateness of the demand, we stress three observations: *a*) a striking percentage of emergencies is considered as «without disorder» or «mildly ill» by the clinicians; *b*) 25.8% of the urgent patients are referred after the first interview in Primary Health Care and 4% do not require treatment; and *c*) the MHC clinicians consider that the referral pathway of 51% of the emergencies is not the adequate one.

Some articles[38-39] mention that urgent psychiatric demand does not only exist due to the psychopathological symptoms but also due to the context in which they appear and the repercussions on it. This could explain why the urgent assessment of the referring physician is not the same as the criteria as the MHC clinician. We propose several hypotheses in this regards: *a*) lack of coordinated and unambiguous definition in the concept of «urgent» by the referring service and the MHC; *b*) the decision to refer urgently is affected by other factors that are not recognized by the referring physician, and *c*) the erroneous referral may respond to the difficulty to control critical life situations, due to lack of security in the professional or deficits in the health care setting.

In relationship with how the patients themselves see the intensity of their symptoms, they tend to consider it as moderate-serious intensity, basically in the emergency services. We could question up to what point the experience of their malaise would condition the referral route, or if, on the contrary, this self-perception is conditioned by the implications of the disorders on their family.

Although the void of social support and a small social network are mentioned as a factor associated to the emergency, our results do not show this. More than 70% of both the patients seen in programmed care as well as the emergency one state they have someone that can go to, although they feel understood and supported in a smaller proportion. The difference between emergencies and programmed visits is associated with experience of loneliness, that seems to correspond more to an intimate and subjective feeling independent of the objective social network of the individual. However, this aspect would need more research.

Nonetheless, we think that clinical seriousness is a factor that can mark certain differences between the pa-

tients referred to the Emergency Services and those referred through programmed visits in which the referring physician, the patient and the specialists in the MHC can coincide. A total of 85% of the emergency patients consider that their problem has moderate or serious intensity; 63% of the clinicians of the MHC consider the patient to be moderately or seriously ill; 36% of those referred from Primary Health Care appear to be justified by the clinical seriousness. Although this factor may serve to differentiate the referral route, it is not a specific variable since many cases referred as urgent do not fulfill the seriousness criteria from any of the agents involved.

Finally, we can conclude with the difficulty of establishing a differentiating profile between the patients who come by means of the emergency visit and those who have used the programmed one. We think that the factors that condition emergency referral are difficult to define; there are other concealed elements (especially relational) going beyond the explicit factors that condition the referral and whose measurement through operative questionnaires is still deficient.

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