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Preliminary study aimed at the construction of a questionnaire for referral from primary care to mental health services

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The high prevalence of psychiatric morbidity in primary care, the growing perception of the need for specialized help by the least severe patients and the lack of accuracy in referrals, contribute to the increasing overload in mental health services. So it seems necessary to design diagnostic tools in order to improve the detection of more severe patients and to help in the referral decision. With this purpose in mind, we have designed the multidimensional hetero-administrated Scale Referral Criteria for Mental Health (CRMH). This paper presents the preliminary results of a pilot study on its application in a sample of 198 patients by a group of Primary Care Physicians (PCP). The data show the detection of a high percentage of potential psychiatric patients (46.9%) and 4% of patients who having the possibility of being referred. The results also illustrate the low ability of PCP to detect these disorders. CRMH has a moderate correlation with the General Health Questionnaire (GHQ) and with detection of psychopathology by PCP. Other factors, apart from clinical severity evaluated through CRMH, possibly belonging to doctor-patient relationship, which should be analyzed, seem to influence the mental health referral. In a future article, we will present the validation of this scale in our care setting.

Key words:
Questionnaire. Criteria. Referral. Primary care. Mental health services.

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Estudio preliminar dirigido a la construcción de un cuestionario de derivación de la atención primaria a los servicios de salud mental

La alta prevalencia de morbilidad psiquiátrica en atención primaria, la mayor percepción de necesidad de ayuda de los casos más leves y que las derivaciones sean poco discriminadas incrementa la presión asistencial en los servicios de salud mental. Todo ello hace necesario disponer de instrumentos que mejoren el reconocimiento de los casos más graves y que ayuden en la toma de decisión de la derivación. Con esta finalidad hemos elaborado una escala con criterios de derivación a salud mental (CDSM) que es multidimensional y heteroaplicada. En este trabajo se muestran los resultados preliminares de su aplicación por un grupo de médicos de atención primaria en un estudio piloto realizado sobre una muestra de 198 pacientes. Los datos obtenidos confirman la existencia de un alto porcentaje de posibles casos psiquiátricos (46,9%) y detecta un 4% de casos susceptibles de derivación. Los resultados también ponen de manifiesto una baja capacidad de detección de dicha patología por parte de los médicos de atención primaria. La CDSM presenta una moderada asociación con el General Health Questionaire (GHQ) y con el reconocimiento de psicopatología por el médico de atención primaria. Otros factores diferentes de la gravedad clínica evaluada por el CDSM, posiblemente pertenececientes a la relación médico paciente y que convendría estudiar, parecen estar influyendo en la decisión de derivación a salud mental. En un trabajo ulterior se publicará la validación de la escala para nuestro entorno asistencial.

Palabras clave:
Cuestionario. Criterios. Derivación. Atención primaria. Servicios de salud mental.

INTRODUCTION

The absence of a specific instrument that helps to improve referral criteria from primary care to mental health care and that can be applied in our psychosocial setting contributes to the inability to discriminate different care profiles on the two levels. The purpose of this preliminary study is to try to cover this gap by constructing a multifactorial scale.

Increase of adaptive disorders against the stagnant position of the most classical diseases indicated by the WHO[1], the high prevalence of mental disorders in primary care[2,3], that may reach 40%-50% if the minor mental disorders are included[4-7], the difficulty we face to detect such disorders on this level as well as screening problems[3,8,9,10] and the high perception of the need for help in the mildest diseases in de-

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triment of the more serious ones[11,12], all result in an important increase in referrals to mental health services[11,12].

Although there are several instruments that have been developed for the detection of psychiatric disorders[13-28], and some of them (GHQ, PRIME-MD, MINI, QPD, PHQ) are especially useful in primary care, they are generally not very useful for the doctors on that level as they feel that they are too time consuming[25].

Such an instrument that would orient the doctor specifically regarding referral or not of the psychiatric case detected, establishing *cut-offs* that would identify the referral indication, would be helpful. In our opinion[13], as in that of others[14-16], the severity and complexity of the case should be its defining factor on the care level in which the care is given. However, referral criteria from primary care to mental health care generally depend on many other factors: the skill of the doctors to detect it, their attitudes towards the psychiatric problems, etc.[29-34], it being in the least serious cases and in the anxious-depressive type ones where the least agreement is seen in the diagnosis and need for referral[34].

Due to this situation, the primary purpose of this study was established with the intention of reducing the multiple factors involved in the referral decision through the elaboration of the multidimensional scale that includes severity criteria. With this in mind, we have aimed to construct a simple instrument that is easy to apply and that would help the Primary Care physician in this decision.

In this first work, we established this construction of a discriminative scale that contains adequate Criteria of Referral to Mental Health (CRMH). Its validation in a subsequent phase is pending since we are only proposing to reach the following objectives at this time:

- Elaborate the scale (CRMH) for referral from primary care to mental health care and evaluate if it discriminates the cases based on severity criteria.
- Examine the functionality of the scale among primary health physicians.
- Compare the detection of psychiatric diseases by primary care physicians included in the study, using the CRMH, GHQ and clinical interview, in a sample of patients.

METHODOLOGY

Construction of the scale

This preliminary, observational and descriptive type study is oriented towards constructing a referral scale that contemplates the case severity criteria. The scale design has been made by first considering the preexisting bibliography regarding the dimensions that define clinical severity: presence of an amount of symptoms, quality of such symptoms and their repercussion from the different perspectives from which they can be contemplated[35-44].

A Delphi work group was used to do so, using a two phase methodology (in the first, the first questionnaire was elaborated and sent to the expert's panel. After receiving their answers, these were analyzed statistically and then a second questionnaire was made, including the analysis of the answers to the first questionnaire. In the second phase, the second questionnaire was sent and after receiving the answers, a final statistical analysis was performed and the conclusions presented. Ten expert psychiatrists in community mental health and coordination with primary care participated in the Delphi group[13]. All of them had care and management responsibilities as staff in public mental health services.

We based the final construction of the scale items on the dimensions of the Global Assessment of Functioning (GAF) scale[45] and EEAG[46] (GAF in Spanish) of Spitzer, also including the clinical dimension and functionality level as proposed by other authors[35], as well as psychosocial, comorbidity and treatment response factors. All these were severity dimensions, which we used with the final objective of making it possible to apply it in the usual care, which is the purpose of this study.

Based on the mentioned references, we have construction the Criteria of Referral to Mental Health (CRMH) (annex 1) and we have also defined examples and made a glossary (that is not included in this work as it exceeds the permitted size). It is a heteroadministered, multidimensional and unit scale of psychiatric severity that evaluates and assesses the situation of the subject over the last month[47,48].

The CRMH, with the different dimensions that make it up, has a simple scoring system that covers a continuum going from a hypothetical situation of extreme severity (score: 0) to one of maximum health (score: 100). The cut-off below 55 points has been identified initially as threshold to identify the possible case to be referred. This cut-off has been identified by the previously mentioned expert's consensus since there are no other questionnaires with the same purpose that can be used to make a convergent validation. The score provided by the CRMH is grouped into ten equal range intervals and the attitude to take regarding the convenience that the intervention should be continued on the primary care or specialized care level is suggested for each one of them.

Application of the scale

Although there is no agreement on the sample size required to study reliability of a scale[49], Kline[50] recommends using a size of 200 individuals for a 95% confidence index.

Based on this, the scale was applied by 10 primary care physicians belonging to a 4 health care sites from two dis-

Annex 1 Referral criteria scale

Patient: ..... **Date:** .....

Symptoms	Global functioning	Psychosocial factors: groups/risk situations		Comorbidity	Response to previous treatment	Range
Non-existent	Optimum all the areas					100 91
Increase daily concerns	Good all the areas					90 81
Possible short-duration mild reactive symptoms (< 1 month)	Brief decrease of ability in some areaa					80 71
Reactive symptoms of greater duration (> 1 month): Mild and non-specific Does not form a syndrome	Decrease of ability in several areas. No support required					70 61
Symptoms: Depressive/ anxious + Intense + Persistent They may form a syndrome	Difficulties in general functioning 3 Support required	Non-existent: Risk group Risk situation	 No Yes No Yes	No Yes	No or good Bad	60 51
Syndromes defined: Psychotic Depressive Severe anxious Addictions Etc.	Severe difficulty in at least one of the areas (family, work, self-care) Substitution of these required	Non-existent: Risk group Risk situation	 No Yes No Ye	No Yes	No or good Bad	50 41
Syndromes defined + alteration reality de realidad judgment Or lack of disease awareness	Severe difficult in several areas (family, work, self-care) Substitution and supervision required	Non-existent: Risk group Risk situation	 No Yes No Ye	No Yes	No or good Bad	40 31
Syndromes defined + alteration reality judgment ↓ Total involvement of behavior	Severe difficulty in all the areas ↓ Need for maintained supervision and support	Non-existent: Risk group Risk situation	 No Yes No Ye	No Yes	No or good Bad	30 21
Alteration reality judgment + total involvement of behavior ↓ Dangerousness	Intense helplessness situation ↓ No self-help ability	Non-existent: Risk group Risk situation	 No Yes No Ye	No Yes	No or good Bad	20 11
Imminent dangerousness	No self-help ability					10 1

Intervention levels

100-91: Not required
90-81: Not required
80-71: Primary care (occasional)
70-61: Primary care
60-51: Primary care or specialized care
50-41: Primary care + out-patient clinic or specialized care
40-31: Specialized care (possible preferential referral)
30-21: Specialized care (preferential referral)
20-11: Specialized care (preferential) or hospital emergencies
10-1: Hospital emergencies

tricts (Usera and Villaverde) of Area 11 of Madrid. A previous meeting was held with them to inform them about the study purpose and to instruct them on the enrollment of patients and how to standardize both the psychopathological detection by interview as well as the application of the CRMH. They were also instructed on how to fill out two questionnaires (annexes 2 and 3), one on the utility and another on the difficulty regarding the application of the scale. Each one of the primary health care physicians administered the CRMH to 20 patients who were selected using a randomization table from those who came to the clinic (excluding those who only came for prescriptions). The members of the research team asked the patients to self-administer and fill out the GHQ-28 items after the medical visit and after informing the patients about the study and asking for their consent. A total of 198 patients over 17 years of age were evaluated. There were only two refusals, related with the impossibility of filling out the questionnaire due to visual deficit.

The variables identified for the analysis were: age, gender, civil status, psychopathology detection, GHQ score, CRMH score, utility of the scale, appropriateness of the scale and adaptation of the scale. Variables related with the reason for the visit (described in the questionnaire), symptom characteristics (anxiety, depression, insomnia, toxic usage, psychotic symptoms) and treatment used (antidepressants, anxiolytics, hyponotics, neuroleptics, etc.) were also gathered.

Statistical analysis

The basic statistics of the central tendency, dispersion and frequencies were calculated for the description of the variables observed. Analysis of the detection of psychopathology by the doctors regarding the probable case by GHQ was done using the chi square test and distribution of the scores on the referral scale by the different doctors and the possible relationship between said scores and the detection of psychopathology was analyzed with the one-factor ANOVA statistics. Pearson correlation coefficient was used for the calculation of the linear association strength between GHQ scores and the referral scale. The analyses were made using SPSS 11,5 for a significance level (alpha) of 5%.

RESULTS

The 198 patients included in the study had a mean age of 45.8 years (SD: 17.65) and 65.7% were women. The primary reason for the visit and that expressed by the patient was psychic disorder in 36 cases (18.1%), regardless of whether there was added organic disease or not. On the other hand, by means of clinical interview, the primary care physicians making the interviews detected psychopathology in 51 cases (26.4%).

Mean GHQ score in the total sample was 6.99 (95% CI: 6.02-7.96), with no statistically significant difference between the mean GHQ score of the groups enrolled by the different doctors participating in the study. A score greater than 5 in the GHQ was considered as cut-off for the identification of possible psychiatric case. In this way, 93 possible cases (46.9% of the total sample) were identified, 68 of whom were women. Of the cases identified by the GHQ, only 44.1% were also identified by the primary care physician. Agreement between both detections was found in low values, with a kappa index of 0.35 for the total number of interviewing doctors, it being 0.49 for the male doctors and

Annex 2 | **Questionnaire to be filled out after the evaluation of each patient**

Name of patient: .....
Gender: ..... Age: .....
Reason for visit: Organic disease ..... Yes ..... No .....
Psychiatric symptoms ..... Yes ..... No .....
Both ..... Yes ..... No .....
Was any type of psychiatric disorder detected in the clinical interview? Yes ..... No .....
Was the application of the scale useful to make the decision on the possible referral to specialized care? Yes ..... No .....
Did you have any problem in assigning this case to a possible score? Yes ..... No .....
The problem was:

- Due to complexity of the case? ..... Yes ..... No .....
- Due to the global ambiguity of the scale? ..... Yes ..... No .....
- Because it did not discriminate well between the groups? ..... Yes ..... No .....

Do you think that the scale took more time in this case to make the decision than if you had not used it? Yes ..... No .....
If you found any type of psychiatric symptoms and the patient was not referred to specialized care:

- What types of symptoms were found? .....
- Did you prescribe any type of psychodrug? Which? .....

Annex 3 | **Questionnaire to fill out after having evaluating all the patients**

Considering the scale proposed as a whole, do you think that:

It is pertinent (evaluate from 1 to 10) .....
The objective proposed is adequate (evaluate from 1 to 10) .....
It clearly differentiates the score groups (evaluate from 1 to 10) .....
The definitions of the glossary are clear and sufficient (evaluate from 1 to 10) .....
It adapts to the cases seen in primary care (evaluate from 1 to 10) .....

Do you consider that it help in decision making on referral? (evaluate from 1 to 10) .....
Do you think that the scale may save you time and increase your accuracy when deciding on referral with a little training? (evaluate from 1 to 10) .....
In how many of the patients was it easy for you to classify them within the scores? .....
and in how many was it difficult or complicated .....
Do you thin it may be useful to have a scale (this one or another similar one) to help determine the need for referral of your patients to specialized care? .....
Yes ..... No .....
In relationship to the scale proposed, what changes would you propose to improve it? .....

0.30 for the female ones. This detection capacity, based on its relationship with a GHQ > 5 (possible case) had low detection levels regarding GHQ ($p < 0.001$), with a 44.1% sensitivity and 90.1% specificity (table 1).

The values found in regards to bias, accuracy and identification index of the physicians participating in our study are shown in table 2. The bias and accuracy concepts and identification index are the indexes proposed by Goldberg and Huxley[51] for the analysis of the general practitioner's ability to detect psychiatric morbidity and the formulae collected by Padierna[6] of a 2 × 2 contingency table and GHQ-28 screening test (probable/non-probable case) and the detection of psychopathology by the doctors (yes/no) have been applied for their calculation.

Table 1 | **Relationship between cases in which the doctors detect psychopathology and probable cases with score > 5 according to the GHQ-28**

Psychopathology detection	GHQ score	
	GHQ ≤ 5	GHQ > 5
No	91	52
% cases with psychopathology	63.6%	36.4%
% of probable cases according to GHQ-28	90.1%	55.9%
Yes	10	41
% cases with psychopathology	19.6%	80.4%
% of probable cases according to GHQ-28	9,9%	44,1%

GHQ-28: General Healt Questionnaire of 28 items.

In the case of the CRMH scale, a mean score of 84.76 (95% IC: 82.78-86.73) was obtained. Considering the score of 55 as cut-off, we found that there were 8 cases (4%) which were below this score and that would have the possibility of being referred to specialized care. Of these, only one was referred, it being stated in the other three cases that the patient rejected the referral.

The evaluation of the relationship between the score obtained on the GHQ by Pearson's correlation coefficient and that obtained on the referral scale CRMH provided us with a moderate association ($r = -0.582$; $p < 0.001$) (table 3).

Equally and using the ANOVA statistical program, we found a significant relationship between scale score and detection of psychopathology ($F = 204.734$ and $p < 0.001$) (table 4).

Table 2 | **Indexes of bias, accuracy and identification of doctors participating in the study**

Research	No. of doctors	Test	Bias	Accuracy	Identification index
Study 2003	10	GHQ-28	1.6	0.68	0.44

GHQ-28: General Healt Questionnaire of 28 items.

Tabla 3 Relationship between GHQ score and referral scale

		GOLDBTOT	Score
GOLDBTOT	Pearson correlation	1	–0.582
	Sig. (bilateral)	0.0	0.000
	N	199	198
Score	Pearson correlation	–0.582	1
	Sig. (bilateral)	0.000	0.0
	N	198	198

GHQ-28: General Healt Questionnaire of 28 items.

Table 4 Relationship between referral scale score and psychopathology detection

	Sum of squares	gl	Mean square	F	Sig.
Inter-groups	19917.342	1	19917.342	204.734	0.000
Inter-groups	18581.269	191	97.284		
Total	38498.611	192			

In regards to the functionality of the scale in relationship with the applicability of the CRMH for the patients, the doctors had no difficulty scoring the scale in most of the cases (93.75%). In relationship to acceptance and utility of the referral scale, the doctors gave the scale a 7 over 10 evaluation for the different aspects evaluated: appropriateness, adaptability and ability to differentiate between different ranges, this being 7.36 and 7.72, respectively, in re-gards to appropriateness to the cases and the definition of the glossary.

The CRMH scale is considered to be globally useful by most of the evaluating physicians (9 out of 11 doctors), however, they decrease their assessment (5.4 over 10) in regards to if it helps them in their decision making on referral or if it saves them time and improves accuracy (5.8 over 10). On the other hand, they consider it useful to decide on referral in 45.7% of the patients and consider that it is time-saving in 48.8% of them.

DISCUSSION

Our results support the existence of an elevated psychiatric morbidity in the primary care visits of the districts where the study was conducted (Villaverde and Usera), with high mean score on the GHQ (6.99) and high percentage of possible psychiatric cases (46.9%). There are no significant differences in its distribution among the doctors of the different primary care teams. This value is somewhat higher than those usually found, with similar research methodology, using the GHQ 28 (version validated by Lobo et al.[52], (cut-off 5/6, sensitivity 84.6%, specificity 82%)[2,6,7], that range from 20%-46%. This may be due to the characteristics of a low socioeconomic level of the study population[53]. On the other hand, the psychic morbidity directly detected by the doctors is at 26.4% of the sample. This approaches the values found by other authors of 26.7%[6] and 23.4%[7].

Similarly, and regarding the relationship between our CRMH scale and the GHQ, it is observed that there is a moderate association (–0.582) between the scores obtained in both evaluation instruments. This association does not vary even when the extreme cases are eliminated. Equally, there is a relationship between the CRMH scores and the detection of psychopathology. This suggests that this referral scale includes the most serious cases and those in which the doctor has detected the existence of psychiatric disorders.

When the CRMH was used, it was found that 4% of the total sample (that represents 15.6% of all the cases in which the primary care physician detects psychopathology) are subject to being referred to specialized care (because they have a score on the scale of <55), a percentage that is similar to the 3.6% found by other authors7.

The low detection ability of the psychiatric diseases found (44% of the possible cases identified by the GHQ), is similar to that found in other studies. This places it between the 50% found by some authors[4,8] and the 35% we found[50,9]. However, the low Kappa index that the evaluators have regarding the identification of cases according to the GHQ is more outstanding. We have found 0.35 kappa values for the total group, that breaks down to 0.49 for the male doctors and 0.30 for the female ones. This factor could be related with the existence of these other factors not related with the disease and the patient and that depend more on subjective aspects of the rater[7,29-33,54].

It is precisely these variables that are unrelated to the case severity that may help us to understand the evaluation made by the doctors of the scale applied. Thus, although they consider it pertinent, adequate and adapted to the cases studied (7.3 over 10) and evaluate the need for a scale of such characteristics, they do not believe that the scale saves them time and that is would be useful (mean of 5.8 and 5.4 over 10). Indirectly, this confirms the weight that factors other than clinical severity have on the decision for referral from primary care to mental health care and that they need to be identified for their specific consideration in the creation of an instrument that help in the decision of referral to mental health care.

On the other hand, the results obtained in this study regarding those obtained by others[7], in regards to bias (that orients us towards the concept of psychiatric disorder that the primary care physicians have), to accuracy (that refers to the agreement between the diagnoses between doctor and questionnaire) and finally to the index of identification on sensitivity (ability of the doctors to diagnose the cases detected by the questionnaire) can be compared in table 5.

As seen in table 5, and comparatively, the doctors of our study have a wide concept of psychic disorder, high accuracy and mean identification index, although the latter is low in general in all the studies.

The special sociodemographic characteristics of our study population, of low/middle-low level, limited sample size, and above all the absence of other reference scales that can be used to compare our results, are limitations to keep in mind as well as the possible bias in the scoring of the scale by the participating doctors.

CONCLUSIONS

- There is high psychiatric morbidity among the study population (46.9% of possible psychiatric cases with a GHQ>5).
- Doctors only detect 44% of these possible psychiatric cases (sensitivity of 44.1% and specificity of 90.1%).
- A total of 4% of the patients will have the possibility of referral to mental health (score on CRMH<55).
- The score obtained on the CRMH has a moderate association with GHQ and a clear one with the detection of psychopathology.
- Other factors, apart from the clinical severity evaluated with CRMH, seem to be influencing the decision of referral of patient to mental health care. It would be recommendable to propose studies that attempt to identify these factors, outside of the disease, and that seem to belong to the patient-doctor relationship.

Table 5 Characteristics of the detection ability of the primary care physicians

Research	No. doctors	Test	Bias	Accuracy	Identification index
Goldberg, 1980	45	GHQ-28	1.46	0.33	0.80
Marks, 1979	91	GHQ-60	0.79	0.39	0.54
Wilmink, 1989	30	GHQ-30	1.84	0.41	-
Boardman, 1987	18	GHQ-28	0.62	1.19	0.36
Schein, 1977	32	GHQ-30	0.45	-	0.31
Martínez, 1993	10	GHQ-28	0.45	0.66	0.29
Rico, 1993	6	GHQ-28	0.57	0.68	0.40
This study, 2003	10	GHQ-28	1.6	0.68	0.44

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