General practice referrals to a community team for mental health in the elderly: information and the mode of referral

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SUMMARY

Referrals by general practitioners to a community health in the elderly team by telephone and letter were compared for the information provided. Significantly less information was available to the team when the referral was by letter, particular in the areas of suicidal tendencies, patient telephone number, and possible informants. The implications of these findings are discussed.

Keywords: mental health; elderly; referrals.

Introduction

MUCH research has been undertaken into the referral of those with mental health problems from primary into secondary care.[1] Factors related to the permeability of this 'third filter' have been identified; severity of clinical picture, sex, living in urban areas, and treatment failure are all important.[1] The general practitioner's (GP's) explicit reasons for referral have been investigated,[2] as has the accuracy of their information on the drugs taken by the person referred.[1]

To date, little work has been done on the influence of the mode of communication of the referral on the information imparted by the referrer to the mental health team. In 1990, a pro forma was designed for the administration staff of a community team for mental health in the elderly (CTMHE) to follow when talking to a person referring a patient. This outlined the basic information to be collected from the referrer in addition to the information given freely by the referrer. The pro forma was used as a basis to measure the information available to the team members to help them to prioritize cases and to prepare them prior to the home assessment.

Method

A random sample of case notes was pulled from the archives of a CTMHE based on the following criteria:

- the referral was made by a GP
- the referral was not a re-referral
- the referral was made after 1990 and the introduction of the new pro forma.

One hundred cases were identified, 50 referred by telephone and 50 by letter. Each item on the pro forma was scored. Any item that received a comment was scored positively even if the comment was negative (for example, 'She does not suffer from incontinence'); items were scored negatively if they received no information at all, positive or negative. In notes where 'depression' appeared in the referral, references to suicidal intent were sought (these were similarly scored). In addition, the notes were perused for evidence that a call had been made back to the referrer for more information. The differences between the letters and the telephone referrals were calculated using chi-square tests.

Results

The results are summarized in Table 1. Although there are relatively few statistically significant differences between the letter and the telephone referrals, there is a general trend for more information to be available to the team through telephone referrals. These brought with them significantly more information than the letters (54.7% and 43.6% of the possible total respectively; $\chi^2 = 9.16$, df = 1, $P = 0.01$).

A referral by telephone was more likely to provide the patient's telephone number ($\chi^2 = 6.45$, df = 1, $P = 0.05$). Telephone referrals were more likely to give information about a next of kin ($\chi^2 = 6.4$, df = 1, $P = 0.05$) and to supply the next of kin's telephone number ($\chi^2 = 5.00$, df = 1, $P = 0.05$). The referrer was also much more likely to give information about suicidal tendencies when asked on the telephone than when asked by letter. Depression was mentioned 27 times in telephone referrals and 31 times by letter, while comments about suicidality were recorded 12 times in telephone referrals but only three times by letter ($\chi^2 = 12.46$, df = 1, $P = 0.01$). There was a greater likelihood of the team knowing that the person referred was aware of the referral if it was made by telephone ($\chi^2 = 12.46$, df = 1, $P = 0.01$). Despite the relative lack of information provided by both referral methods, calls back to the GP were rare (seven from telephone referrals, four as a result of letters).

Discussion

Both methods of referral provide relatively small amounts of information judged against the 1990 pro forma. It is likely that both the GP and the administration staff knew more about the cases than they recorded at the time of referral. Items that were not clinically important to the case (for example, whether a person with anxiety was continent) would probably not be put in a letter. Equally, administration staff who have become increasingly practised at taking histories from all-comers are unlikely to request or record information that is not relevant to the case, and will perhaps not record information that is asked about if the answer is negative or if the referrer is not forthcoming.

For any assessment in old age psychiatry to be complete, an informant must be sought. This is particularly the case for people who have cognitive impairment and who may not be able to identify the right person to contact or to tell you how to contact them. If this information is available at the time of referral it is invaluable. The study shows that GPs frequently have this information when asked but do not routinely give it in letters. Equally, it is useful to be able to contact a patient by telephone to make an appointment and explain the nature of your visit.

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Submitted: 25 July 1996; accepted: 4 February 1997.

Table 1. Information given by telephone and letter (n = 50 unless stated).

	Telephone	Letter
Patient's name and address	50	50
Patient's date of birth	49	48
Patient's telephone number	41	21[a]
Patient's marital status	21	26
Next of kin: name	28	12[b]
Next of kin: telephone number	31	14[c]
GP's name	50	50
GP's address	45	50
Diagnosis	26	31
Past psychiatric history	10	7
Social services/community care input	14	9
Current medication	47	31
Sleeping pattern	16	10
Eating pattern	18	7
Signs of physical illness	29	21
Incontinence	2	0
Strange ideas	22	31
Strange behaviour	28	21
Length of presenting complaint	30	22
If depressed, any suicidal complaints	12/27	3/31[d]
Patient aware of referral	22	4[e]
Potential problems of access	6	1
Was a telephone call made for clarification?	4	7

[a]$\chi^2 = 6.45$, df = 1, P = 0.05; [b]$\chi^2 = 6.4$, df = 1, P = 0.05; [c]$\chi^2 = 5.00$, df = 1, P = 0.05; [d]$\chi^2 = 6.74$, df = 1, P = 0.01; [e]$\chi^2 = 12.46$, df = 1, P = 0.001.

The second important area where the telephone call provided important information not presented in letters was the issue of suicidal thoughts. Being elderly is one of the major risk factors for suicide. Assessment of suicide risk is a vital part of assessment in any person who is thought to be depressed.[4] Such thoughts are important when prioritizing patients. It could be argued that the discrepancy between the use of telephone and letters on this issue arises because the GP is much more likely to telephone than to write for an urgent assessment if the person is expressing suicidal ideas. This hypothesis could not be investigated from the data collected. There is generally a low rate of recording the presence or absence of suidical ideas in referrals in either mode. Any person showing depression as part of their clinical presentation should have their suicide risk assessed and recorded.

An alternative method of improving the collection of data would be the introduction of a simple referral form which would include prompts about the information that the CTMHE team desires in addition to space for free text. A number of problems arise from this method: first, yet another piece of paper has to be found and filled in; secondly, information that is not seen as relevant by a GP but that may be valued by the team would still be omitted; thirdly, the human contact between the GP and the teams would be lost; fourthly, the chances for both parties to learn would be diminished; and finally, form filling and postage would further delay contact between the CTMHE team and the patient.

Conclusions

General practitioners often know their patients better, and have more information about them, than other professionals working with them. In the assessment of the elderly and mentally ill, this information can be vital in providing a comprehensive assessment.

If a referral to a CTMHE is made by letter, it is likely that significantly less information will be passed to the assessors than if the telephone is used. It may be argued that information such as the next of kin and their telephone number are not important enough information to engender a change in practice; however, it must be remembered that many patients, particularly those with dementia, may not be able to provide this information to the assessor, thus precluding liaison with their family. GPs should be encouraged to make their referrals by telephone, preferably with the patient's records to hand; this would save time both for the themselves and for the patient. CTMHEs would need to reciprocate by providing a rapid answering service and adequately trained administration staff to take the details in an agreed manner.

References

1. Goldberg D, Huxley P. *Common mental disorders. A bio-social model.* London: Routledge, 1992.
2. Ball CJ, Payne M, Lewis E. Doctors and nurses. General practitioners' referrals to different arms of an old age psychiatry service. *Int J Geriatr Psychiatry* 1996; **11:** 995-999.
3. Clarke NA. What the eye doesn't see: drugs psychiatrists don't know their patients are on. *Psychiatric Bulletin* 1993; **17:** 469-470.
4. Ball C. Old age psychiatry. In: Rees L, Lipsedge M, Ball C (eds). *Textbook psychiatry.* London: Arnold, 1996.

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