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Self-Referrals to a Community Mental Health Centre: A Three Year Study

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The records of all 53 clients who referred themselves to a community mental health centre in the first three years of its existence were studied retrospectively. These showed increasing and generally appropriate use of direct access for the relief of serious, often long-standing emotional distress. Self-referrals were much more often men than women, and some clients would probably not have been reached in any other way. The service seemed to reduce the local GPs' burden, at least subjectively. However, no-one presented with acute psychiatric disturbance or immediately impending breakdown. Any prevention achieved seems likely to be long-term rather than short-term.

A controversial aspect of the work of community mental health centres is direct access of the service to the public. There are fears that many people will refer themselves inappropriately, waste professional time or become unnecessarily dependent, or even that disruptive characters may walk in from the street and cause chaos. On the other hand, there are hopes of preventing breakdowns through early intervention, and of reaching persons who do not use more traditional settings. One might even expect high motivation in clients who establish contact on their own initiative.

With these issues in mind, all records of self-referrals to the Eastgate Community Mental Health Centre between 1.4.80 and 1.4.83 have been studied retrospectively in an attempt to obtain a picture of these clients, of the needs they express, and of the outcome of their contact with the centre.

The Eastgate Centre

This community mental health centre opened in Lewes in September 1979, and was fully operational in early 1980. It offers a service to the adult population (age range 16–65) of an area of East Sussex (Brighton District) which includes several small towns (Lewes, Newhaven, Peacehaven, Seaford) and rural areas, totalling about 70,000 inhabitants of very mixed social class. The population is a fairly stable one on the whole, although Lewes has a large prison which releases a number of drifting offenders, and drug users and vagrants also drift to and from Brighton.

Referrals are taken from GPs, psychiatrists, social workers, probation officers, and any statutory and voluntary agency. Self-referrals have also been encouraged from the start. The centre was publicised by leaflets placed in GPs' surgeries, social services and probation offices, public libraries, church halls, and even shops. The centre was also described in the local paper and on local radio when it opened. Publicity made it clear that anyone wanting help with any kind of emotional distress could walk in or make contact between 9 a.m. and 5 p.m. any week day. Loneliness, marital difficulties, bereavement, anxiety, depression, and drinking were more specifically mentioned in the leaflet.

The walk-in service from 9 a.m. to 5 p.m. (except at week-ends) offered immediate assessment by a duty worker. Afterwards, continuing help could be arranged in the centre if appropriate, or clients could be channelled towards other existing services in the area (medical, psychiatric, social, or other agencies) if they seemed more suitable.

The centre is staffed by a multi-professional team (psychiatrist, psychologist, social workers, CPN, OT, volunteers). Most forms of psychological help are available either individually (counselling, psychotherapy) with relatives, or in stranger groups. There is a wide range of groups, including supportive ones (lunch group, discussion group, art group) and more active treatment groups (anxiety management, social skills, psychotherapy). A self-help organisation for alcohol/drug related problems (Libra) holds meetings in the centre weekly. Finally, a coffee lounge is also available for clients to meet informally if they wish during the day.

Self-referrals

Only clients who said that they had contacted the

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centre spontaneously and not at the suggestion of a professional involved with them are considered in this paper. In the first year, clients seem to have responded to the leaflet or to radio and local paper. In the 2nd and 3rd year, most of them had heard through a friend or relative attending the centre. In all, there were 53 self-referrals among a total of 433 clients attending the centre. Of these, six came in the first year and 24 and 23 in subsequent years, latterly accounting for about 20% of total referrals. Of these, 50 walked in without previous contact, two came after writing to the centre, and one after telephoning.

Clients living within walking distance seem to refer themselves increasingly, and equalled those from all other areas put together in the third year, although Lewes has only about 15,000 inhabitants.

The youngest self-referred client was 22, although the centre is available to all over 16, and receives many formal referrals of clients younger than 22. Other ages seem fairly evenly distributed. Thirty men, 17 women, and three couples referred themselves. The high proportion of men to women is unusual in psychiatry and is not found in the rest of the centre population (176 men, 257 women, and seven couples in the same period).

In the first year, five out of the six self-referred clients were unemployed, but this fell to five out of 24 in the second year, and four out of 23 in the third year. The other clients covered the range of occupations from manual work to skilled technicians and professional work (two electronic engineers, one probation officer).

Presenting problems

The main problems identified by clients in the course of their initial assessment are summarised in Table I. These are not formal psychiatric diagnoses. Clients often presented with more than one problem, and the most common difficulties were marital ones. Nevertheless, only three couples referred themselves together and usually only one of the partners came, at least initially. Problems and distress were mostly of some duration, usually several months, or years. 'Transient situational crisis' of the kind described by Brough and others (1983) in Lewisham were uncommon, accounting for only six self-referrals.

TABLE I

Marital problems	17 (3 couples)
Relationship/personality problems	12
Anxiety	11 (including 2 agoraphobics)
Depression	9
Loneliness	8
Practical social difficulties	5
Family problems	4
Drinking problems	4
Eating disorder	2 (1 mild anorectic, 1 compulsive eating)
Drug dependence	2
Prolonged grief	4
Other	1 (husband drinking)

Five clients had received previous treatment for a psychiatric illness, manic-depressive illness (2), schizophrenia (2), and hysterical state (1). They presented because of depression, loneliness, or family problems, not because of clinical relapse. Two clients only subsequently needed admission in the same catchment area (for schizophrenia and depression respectively). No-one required admission at the time of contact.

Outcome

The treatment and outcome of attendance are summarised (Table II). Of those attending groups, anxiety management was time-limited (10 weeks), most marital and individual work was brief (3–6 months), but a few individuals and couples are still attending after over a year, though not necessarily intensively.

TABLE II
Contact with the centre

Clients referred elsewhere				4
Clients dropped out early				18
After first contact		12		
After two–three contacts		6		
Clients involved consistently at the Centre				31
Individual counselling and therapy			13	
Groups:			8	
Anxiety management	5			
Self-help with alcohol (Libra)	3			
Marital therapy			6	
Family therapy			1	
Social support in coffee lounge			3	

Of those receiving individual therapy, three are still attending, four are greatly improved (one dramatic example was a young woman crippled for years by a fear of vomiting in public which completely disappeared within six months), five had made progress, but are left with serious unresolved problems (often marital ones, with spouse unwilling to attend). One patient was considered to have a severe personality disorder, who did her best to disrupt the Centre, bringing in drugs, trying to get at other clients' confidential files, and constantly

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pestering her key worker. She was confronted and left after a few weeks.

All five clients who attended the anxiety management group were rated (and rated themselves) as greatly improved, and the three alcoholics in the self-help group seemed to stop drinking for several months, but all have now left the area.

Of patients receiving marital therapy, two are still attending, three were probably helped to some extent, but assessment is difficult because of the complexity of their problems. For instance, in one couple the wife presented with agoraphobia, but revealed that her husband was a paedophile who had always refused to see anyone for help. Eventually, he also attended. Nine months after the first contact, they moved to another area. She was no longer agoraphobic by then, and he agreed to be referred to a psychiatrist near the new home. One marriage broke down, but the partner, who had attended alone, coped well and felt better eventually.

Only one family presented itself, a mother and daughter with chronic schizophrenia. After two years, they still attend now and then for support but seem to cope better with their relationship, and the daughter is living independently, taking no medication.

At different times, three similar young men, yet apparently unconnected with one another, used the coffee lounge as a kind of refuge during the day and completely refused any other therapeutic involvement. All three were offenders. Two had just come out of Lewes prison and were rejected by their families, one was on probation for drug offences and also in conflict at home. One had to be discouraged from squatting in the centre with his sleeping bag, and was given help to find accommodation.

All three caused anxiety among the staff and provoked long discussions about the wisdom—or otherwise—of tolerating them in the coffee lounge on their own terms. However, they did not seem to upset other clients. Each of them left spontaneously after about 2–3 months, having apparently made reasonable arrangements elsewhere (e.g. fruit picking abroad). None re-offended while attending, and one of them, a recidivist thief, remarked that he would probably have done so had the centre not been accessible.

Comparison of self-referrals with other clients of the centre

The overall early drop-out rate at the centre is 24%, and 22% for self-referrals. In addition, 19% of the referred clients never arrive at all; 5.5% of all clients are referred to other agencies and not taken in at the centre and this happens with 7.5% of self-referrals.

Further comparisons are difficult, because statistics for a truly comparable group are lacking. However, in a survey of 336 attenders, 150 had individual therapy/counselling, 28 marital therapy, one family therapy, 132 were allocated to a great variety of groups (including 49 in anxiety management and five in self-help alcoholic groups), and 36 had 'other' forms of help (coffee lounge support, relaxation, befriending by volunteers, etc.). Some clients used more than one group of approach. The general pattern of need appears similar for self-referred clients. Outcome was studied in 287 consecutive closed cases and compared with self-referred patients, which are indicated in brackets. Fourteen per cent (19%) were rated as greatly improved, 12% (12%) slightly improved, 24% (14%) unchanged, 1.9% (0%) worse. Treatment had not been completed—or even started—in 54%, because of never attending, dropping out, being referred elsewhere, moving, or dying. (A few files were also lost or incomplete). Although the numbers are small, self-referrals would appear to do at least as well as the referred clients.

Contact of self-referred clients with GP

GPs are normally informed of self-referrals with the client's permission, which is rarely refused (one woman refused to reveal the name of her GP, and her own name as well, initially). No GP suggested that the centre was duplicating his work, but it is not easy to know from the clients how much they use their GP as well as the centre, as it was not usually recorded.

A brief questionnaire was therefore sent recently to 15 local GPs—all those in Lewes and neighbouring areas who had been in practice throughout the period considered and had not left since then—to obtain their opinion on this.

They were asked whether they remembered patients who had referred themselves to Eastgate. If so, (1) whether they knew the reason for the referral, (2) whether the patients were frequent attenders at their surgery, (3) whether, after self-referral, patients attended more, less or the same as before.

They were also invited to make any comment they wished about the service.

Thirteen GPs returned the questionnaire, and eight of them remembered patients who had referred themselves. They "sometimes" knew the reason for the self-referral—not "always" or even

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"usually". Five thought those patients were definitely frequent attenders at the surgery, three thought only "sometimes". They felt patients attended less frequently subsequently, except for one GP who felt it was "the same".

All the comments volunteered were favourable to the service, and described it as "useful", mentioning "prompt attention", "time available to the patient", "a life-line" as advantages.

Discussion

Local factors may have influenced certain findings. The centre had internal problems in its second and third year, and the initial publicity drive was not maintained, which may explain the static figures for all referrals in the third year, and also the increasingly local recruitment of clients from the immediate vicinity, hearing of the centre informally.

The absence of anyone under 22 among self-referrals might be partly linked to the development in Lewes, in the period considered, of a youth counselling service, though this service is mainly used by younger teenagers, and there probably is also some real reluctance in young adults to refer themselves.

Marriage guidance is available in Lewes, but the nearest branch of the Samaritans is in Brighton. They may be relevant to the fact that relatively few couples present themselves, compared to the high number of depressed and lonely individuals who come to the centre. This is generally true of the referred clients too.

The predominance of men, on the other hand, has also been noted in the walk-in clinic at the Maudsley Hospital (Meng Hoi Lim, 1983) and is probably a general rather than a local finding. Men often appear reluctant to seek help for emotional difficulties, and it may be of greater value for them to be able to do so on the spur of the moment, and informally. Several of them in fact indicated that they would not have sought help in a more formal way.

Other workers have found that acutely disturbed psychotics do not refer themselves, least of all during working hours, and this was confirmed here, though clients with a previous history of severe psychiatric illness occasionally sought support.

Most clients, however, presented themselves with very genuine emotional difficulties, often severe and longstanding, sometimes intimate and embarrassing in nature. This contrasts with the prevalence of transient 'situational crises' found in the Lewisham Advice Centre. Perhaps there are differences in the population served, but it is also possible that the way in which a centre is advertised influences who comes forward, and recruitment may be different with an emphasis on 'advice'. Most of our self-referred clients were in fact long suffering people who had struggled on their own a great deal before sharing their troubles. Offering them relief seems worthwhile, and might well have some long-term preventive value, since social and emotional vulnerability factors are being increasingly recognised as important contributors to many forms of psychiatric illness, particularly depression (Brown & Harris, 1978).

The drop out rate is slightly less (22%) than with referred clients (24%), but is still high. Reasons for early drop out are unclear, since non-attenders seldom answered letters. The few who did put forward practical difficulties, except for one man who made it clear that he wanted only a "life-line". Clients who attended consistently seemed, on the whole, to make good and appropriate use of resources. Many felt they were helped. Only one woman was really disruptive, and during the same period several equally disruptive people were referred formally.

The evidence from the three-year period of this study suggests that clients mostly referred themselves appropriately for genuine emotional problems which were often severe and of long-standing, and rarely for a transient crisis. Some of them seemed to gain relief, and would probably not have been reached through a formal referral system. The early drop-out rate was slightly lower than with referred clients. Direct access to the public did not put excessive strain on the centre, and self-referred clients did not seem more disruptive, demanding, or difficult to help than the others.

No immediate prevention of impending psychiatric breakdown occurred, but all self-referrals were new to the centre. The possibility that some already known clients, having a good relationship with the centre, might attend and be helped when they are becoming disturbed is not ruled out. At least, relief of lasting emotional distress and help with disturbed personal relationships often seemed effective, and this may well reduce vulnerability factors in individuals and have some long-term preventive value.

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