

Hospital Admission as First-Contact with a Community-Based Psychiatric Service

A 2 Year Study in South-Verona

C. Faccincani¹, G. Mignolli¹, and P. Munk-Jørgensen²

¹ Cattedra di Psicologia Medica, Istituto di Psichiatria, Università di Verona, Policlinico, I-37134 Verona, Italy

² Institute of Psychiatric Demography, Psykiatrisk Hospital, DK-8240 Århus, Denmark

Summary. The aim of this study was to understand the decision to hospitalize at the first contact, rather than utilize the other services of a community-based system of care. Using the South Verona Psychiatric Case Register, 46 first-contact patients admitted to hospital were compared to all other in-patients ($n = 187$) over a 2-year span with respect to socio-demographic characteristics, diagnosis (ICD-9) and symptoms (on the Present State Examination Syndrome Check List).

Results suggested that first-contact hospitalized patients have significantly more neurotic depressive features. Alternatives to admission were investigated in only about one-third of depressive neurosis patients, compared to two-thirds of patients with other affective disorder diagnoses. In contrast, for patients with psychoses, admission is a second choice (except for patients with organic psychoses).

Key words: Community psychiatric service – First admission – Psychiatric case register – Present State Examination Syndrome Check List

Introduction

In 1978, a new mental health law introduced in Italy radically changed public policy toward the mentally ill. The main features of this law have been described elsewhere [1, 2, 3, 4]. In South Verona most of the patients are treated mainly in the community [5]. To ensure therapeutic continuity [6] the same staff are responsible for both in-patient and out patient care (which includes domiciliary visits and day care). Admissions are to an academic setting, that is, a 15-bed ward located in a general hospital. Data from the South Verona Psychiatric Case Register have been described elsewhere [7]. Most of the patients are not admitted at their first contact with the South Verona Community Psychiatric Service (CPS), since one of the main aims of the service is to provide treatment alternatives to hospital admission (domiciliary visits and home care, day care at the Community Mental Health Centre etc.) even in acute situations.

The aim of the present study was to analyse the characteristics of those patients who, nevertheless were admitted to in-patient care at their first contact with the service.

Materials and Methods

Using the Case Register we identified all patients who, in 1982 and 1983, had been admitted to in-patients care in the South

Verona CPS, and for whom the admission represented the first contact with this service.

In 1982 19 patients (12 males and 7 females), and in 1983 27 patients (11 males and 16 females), a total of 46 (23 males and 16 females) met the inclusion criteria (Group-I). We analysed some characteristics of the patients (sex, age, diagnoses, symptomatology) and some basic data concerning the referrals. We also compared this group of first referred in-patients with the group of all other in-patients admitted during the same period (Group-II, $n = 187$) and with the general population living in the catchment area.

Two Italian psychiatrists (C. F. and G. M.) and a Danish psychiatrist (P. M. J.) (all trained in England in the use of the Present State Examination, PSE-9) [8] reviewed the case notes of the patients in Group-I and separately completed the PSE Syndrome Check List [8] (see Table 1). They were blind to the clinical discharge diagnoses.

Accordingly, Group-I was described in terms of syndrome profiles, arranged in logical groupings, in order to describe the clinical features of the patients independent of diagnoses. The percentages of the presence of each syndrome in the cohort (males, females) were found by calculations based on the formula:

$$\frac{(\text{sum of positive ratings by the 3 raters})}{(\text{number of patients}) \times (\text{number of raters})} \times 100$$

The Register diagnoses of 11 diagnostic groupings based on the ICD-9 [9] (see Table 2) were examined and the average length of stay was calculated. The data were compared with those of Group-II. Finally, some characteristics of the referrals (suicide attempts, police referrals, compulsory treatments etc.) in Group-I were examined.

Results

Tables 3 and 4 show the community orientation indices of the South Verona CPS in 1982 and 1983, years to which this study refers.

The 46 patients included in Group-I represent 19.7% of all patients admitted to hospital in the same years. As far as referrals are concerned, 1 patient had been hospitalized with a compulsory admission, 4 had been referred by the police and 5 had attempted suicide. The average length of stay for patients in Group-I was 10 days, while for Group-II it was 16 days.

Figure 1 shows the age group distribution in Group-I, Group II and in the general population. The patients of

Table 1. The PSE syndrome check list

1 (NS) Nuclear syndrome	21 (SL) Slowness
2 (CS) Catatonic syndrome	22 (NP) Non-specific psychosis
3 (IS) Incoherent speech	23 (DE) Depersonalisation
4 (RS) Residual syndrome	24 (ED) Special features of depression
5 (DD) Depressive delusions and hallucinations	25 (AG) Agitation
6 (SD) Simple depression	26 (NG) Self-neglect
7 (ON) Obsessional syndrome	27 (IR) Ideas of reference
8 (GA) General anxiety	28 (TE) Tension
9 (SA) Situational anxiety	29 (LE) Lack of energy
10 (HT) Hysteria	30 (WO) Worrying, etc.
11 (AF) Affective flattening	31 (IT) Irritability
12 (HM) Hypomania	32 (SU) Social unease
13 (AH) Auditory hallucinations	33 (IC) Loss of interest and concentration
14 (PE) Delusions of persecution	34 (HY) Hypochondriasis
15 (RE) Delusions of reference	35 (OD) Other symptoms of depression
16 (GR) Grandiose and religious delusions	36 (OR) Organic impairment
17 (SF) Sexual and fantastic delusions	37 (SC) "Subcultural" delusions or hallucinations
18 (VH) Visual hallucinations	38 (DI) Doubtful interview
19 (OH) Olfactory hallucinations	
20 (OV) Overactivity	

Table 2. The South Verona Register eleven-fold classification

Diagnostic grouping	Diagnostic ICD-9 numbers:
0. Not known	
1. Schizophrenia and other functional psychoses	295, 297, 298.2, 298.3, 298.4, 298.8, 298.9, 299
2. Affective psychoses	296, 298.0, 298.1
3. Organic psychoses (including dementia, delirium tremens, other alcoholic psychoses)	290-294
4. Depressive neuroses	300.4, 309.0, 309.1, 311
5. Other neuroses (including psychosomatic disorders)	300.0-300.3, 300.5-300.9, 306, 316
6. Alcohol dependence	303
7. Personality disorders	301, 302
8. Other diagnoses (including situational transient disturbances, mental anorexia, mental retardation etc.)	307-310, 312-315, 317-319
9. No abnormalities	—
10. Drug dependence	292.0, 304, 305

Group-I were over-represented in the 25-44 age group (52.2% versus 44.9% of Group-II and 35.5% of general population), and generally tended to be younger, but none of these trends were significant at the 5% level.

Figure 2 shows the distribution as to the diagnostic groups of the patients of Group-I and Group-II.

Table 3. South Verona CPS users receiving out-patient care^a only (NOT IP) or receiving both in- and out-patient care or in-patient care only (IP) in 1982 and 1983

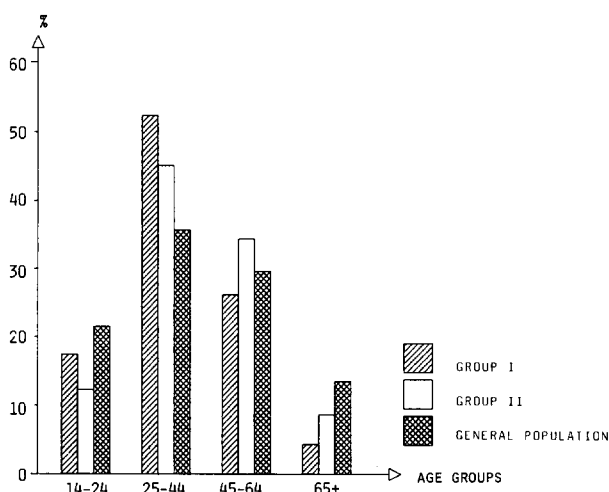
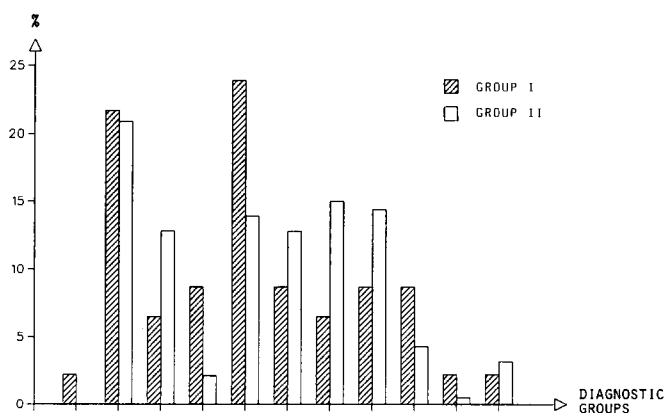
	1982	1983
NOT IP	396	426
IP	109	124
Total	505	550
Ratio NOT IP/IP	3.6	3.4

^a Domiciliary visits and home care; day care at the Community Mental Health Centre, out-patient department care

Table 4. South Verona CPS out-patient contacts^a and admissions to hospital in 1982 and 1983

	1982	1983
Out-patient contacts	2822	4538
Admissions to Hospital	184	247
Total	3006	4785
Ratio $\frac{\text{out patient contacts}}{\text{admissions to hospital}}$	15.3	18.3

^a See note of Table 3

**Fig. 1.** Patients admitted to South Verona psychiatric ward in 1982 and 1983 (males and females) without and with previous contacts with the CPS (Group-I and Group-II), by age. Comparison with the general population**Fig. 2.** Patients admitted to the South Verona psychiatric ward in 1982 and 1983 (males and females) without and with previous contacts with the CPS (Group-I and Group-II), by register's diagnosis (see Table 3)

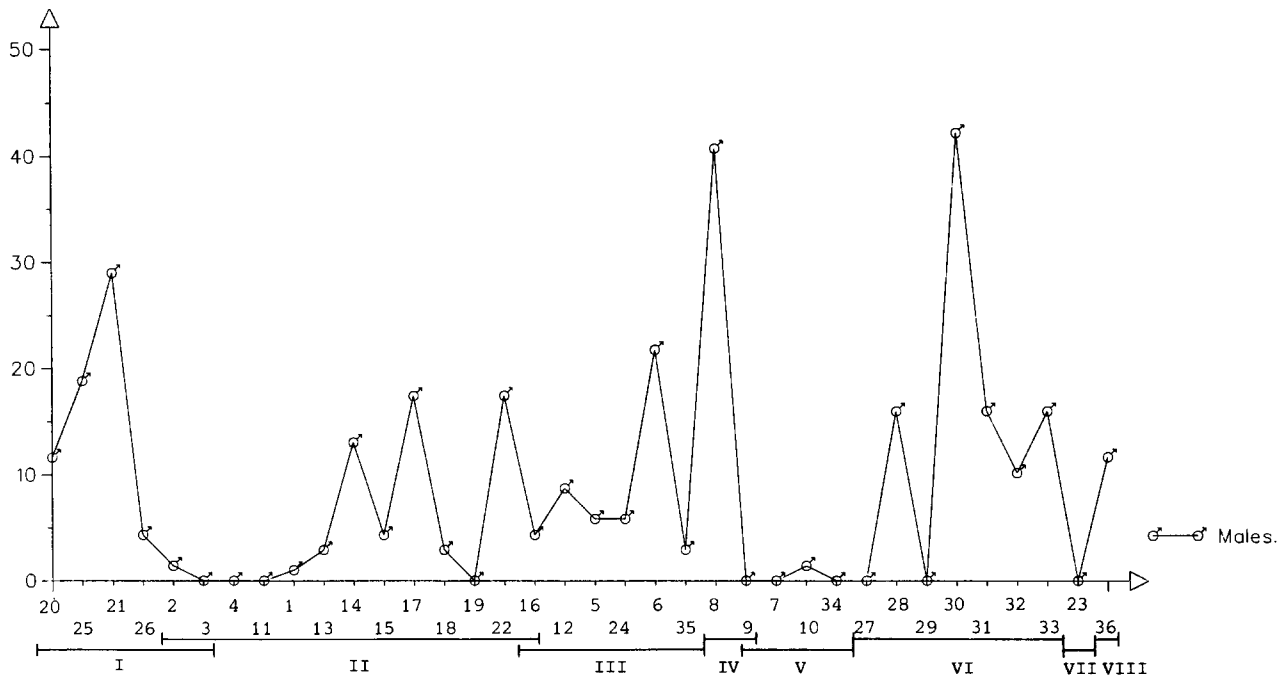


Fig. 3. Syndrome check list [8] applied to case records on 23 first admitted males. *I* Behaviour and speech. *II* Psychotic. *III* Affective. *IV* Anxiety. *V* Specific neurotic. *VI* Non-specific neurotic. *VII* Derealisation. *VIII* Organic (single syndromes-see Table 4)

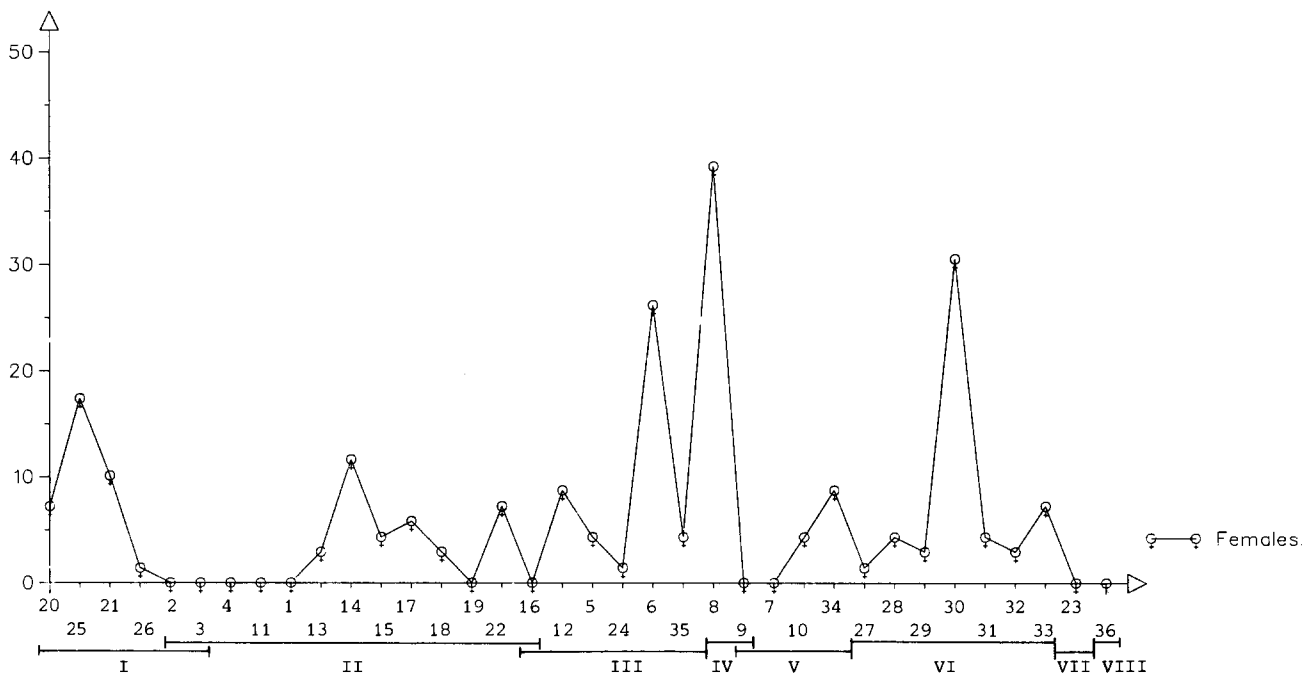


Fig. 4. Syndrome check list [8] applied to case records on 23 first admitted females. *I* Behaviour and speech. *II* Psychotic. *III* Affective. *IV* Anxiety. *V* Specific neurotic. *VI* Non-specific neurotic. *VII* Derealisation. *VIII* Organic (single syndromes-see Table 4)

The following diagnoses were over-represented in Group-I: depressive neurosis, organic psychoses including dementia, transient situational disturbances and “no psychiatric disturbances” but only the differences in depressive neurosis and organic psychosis were significant at the 1% level. The percentages of patients who received a diagnosis of schizophrenic psychosis or other functional non-affective psychosis, were similar in both groups (21.7% vs 20.9%).

The presence of depressive features in Group-I was confirmed by Fig. 3 and Fig. 4, which show the presence of psychi-

atric syndromes in Group-I in-patients, by sex (23 males and 23 females).

We have arranged the syndromes in logical order: behaviour and speech, psychotic (first those including schizophrenic symptoms — next the other psychotic syndromes), then the affective syndromes, anxiety, specific neurotic, non-specific neurotic, derealization, organic. Syndromes 37 and 38 were excluded because of the absence of positive ratings.

There was a peak in the group of behaviour and speech syndromes in both sexes. The syndromes describing psychotic

conditions were remarkably low (more pronounced in females than in males), but there were peaks in delusions of persecution in both sexes, in sexual and fantastic delusions and in non-specific psychosis in males. The affective syndromes and the non-specific neurotic syndromes occurred frequently in both males and females. In both sexes peaks were found in the syndromes of "special features of depression", "other symptoms of depression", and in "worrying", while "tension" was mostly seen in males. The absence of the syndromes of catatonia, incoherent speech, residual, affective flattening, and especially nuclear indicated the absence of more severe psychoses.

Discussion

The aim of this paper was to analyse the characteristics of hospitalized patients, who had no previous contacts with the South Verona CPS, and to understand, if possible, what reasons psychiatrists may have had to admit these patients to in-patient care instead of using other types of treatment.

Analysis of the referrals showed that social turmoil could justify only 10 of the 46 admissions. The presence of neurotic depressive features seemed to be a major differentiating factor between Group-I and Group-II (seen in the case register diagnostic group comparison, and confirmed by the analysis of the syndrome profiles). On the other hand, affective psychoses had greater representations in Group-II. The data suggested that alternatives to immediate admission are searched for in about $\frac{2}{3}$ of all in-patients receiving a diagnosis of affective psychosis, but only in about $\frac{1}{3}$ of all in-patients with depressive neurosis.

In our study immediate admission for psychotic patients seemed to be a second choice, with the exception of those affected by an organic psychosis. For them, the admission to in-patient care can be explained by the lack of an effective, social and sanitary intervention for the elderly by the local administrations. Furthermore, in most of these cases, families seemed reluctant to cooperate, and quite often the demand for admission was an attempt to get rid of an elderly relative. Therefore admission to hospital seems to be necessary in order to co-ordinate more effective interventions in the community and, when possible, to obtain the family's collaboration to find better alternatives.

Finally it is possible that the difference observed in the average length of stay between our study group and the other in-patients points to the difference between a planned admission and an admission made merely as a crisis intervention or as an answer to social upset.

Conclusions

It seems that the presence of "depression" frightens the admitting psychiatrists and this represents a major factor in the deci-

sion to hospitalize. This is probably due to the more or less realistic fear of suicide connected with "depression" (even though only 1 patient of the 11 of the diagnostic group-4 was referred for suicide attempt, and only 1 was referred by the police). It might seem strange that the decision of immediate admission is less related to psychotic conditions; it is well known, however, that community services are designed to function better with psychotic patients to whom they can offer more complex and integrated answers.

Acknowledgements. This study was carried out as part of a programme of research of the Cattedra di Psicologia Medica, Università di Verona, directed by Professor M. Tansella and supported by the Consiglio Nazionale delle Ricerche (CNR, Roma), Progetto Finalizzato Medicina Preventiva e Riabilitativa 1982-1987, Contracts no. 84.02543.56 and no. 85.00786.56. It was conducted during the appointment of Dr. P. Munk-Jørgensen as visiting scientist, Cattedra di Psicologia Medica, Verona.

The authors are grateful to Dr. Annalise Dupont and to Professor Michele Tansella for the advice and supervision they provided, and to Professor Ira Glick for his suggestions on the English text.

References

1. De Plato G, Minguzzi G (1981) A short history of psychiatric renewal in Italy. *Psychol Soc Sci* 1:71-77
2. Mosher LR (1982) Italy's revolutionary mental health law: an assessment. *Am J Psychiatry* 139:199-203
3. Mosher L (1983) Recent developments in the care, treatment, and rehabilitation of the chronic mentally ill in Italy. *Hosp Commun Psychiatry* 34:947-950
4. Tansella M, Meneghelli G, Siciliani O (1982) Implementing a community psychiatric service in South-Verona under the new Italian Mental Health Act. A two-year analysis. *Psychiat Soc Sci* 2:105-114
5. Zimmermann-Tansella Ch, Burti L, Faccincani C, Garzotto M, Siciliani O, Tansella M (1985) Bringing into action the psychiatric reform in South-Verona. A five-year experience. *Acta Psychiatr Scand [Suppl 316]* 71:71-86
6. Faccincani C, Burti L, Garzotto N, Mignolli G, Tansella M (1985) Organizational aspects of community care. The South-Verona Mental Health Centre. *New Trends Exp Clin Psychiatry* 1:201-216
7. Tansella M, Faccincani C, Mignolli G, Balestrieri M, Zimmermann-Tansella Ch (1985) Il registro psichiatrico di Verona-Sud. Epidemiologia per la valutazione dei nuovi servizi territoriali. In: Tansella M (ed) *L'approccio epidemiologico in psichiatria*, Torino, Boringhieri, p 225
8. Wing JK, Cooper JE, Sartorius N (1974) The measurement and classification of psychiatric symptoms. An instruction manual for the PSE and CATEGO program. Cambridge University Press, Cambridge
9. World Health Organization (1978) Mental disorders: glossary to their classification in accordance with the 9th revision of the International Classification of Disease. Geneva, WHO

Received November 5, 1986