Original Paper

Psychopathology

Psychopathology 2013;46:201–205
DOI: 10.1159/000341729

Received: February 23, 2012
Accepted after revision: July 9, 2012
Published online: September 7, 2012

In Need of Psychiatric Help – Leave a Message after the Beep

René Bridler[a] Ariane Orosz[a, b] Katja Cattapan[a] Hans H. Stassen[c]

[a]Psychiatrische Privatklinik Sanatorium Kilchberg, Kilchberg, [b]Department of Psychiatric Neurophysiology, University Hospital of Psychiatry Bern, Bern, and [c]Psychiatric University Hospital Zurich, Zurich, Switzerland

Key Words

Severe mental illness · Acute exacerbation · Wait time · Psychiatrists · General practitioners · Mental health appointment

Abstract

Background/Aim: Every day, a substantial proportion of the general population experiences the distressing and frightening signs of an upcoming psychiatric illness. The consequences can be enormous because severe psychiatric disorders typically cause the loss of the ability to work and often mean a long-term burden for both the patients and their families. Even though most developed countries have an exceptionally high density of general practitioners and psychiatrists in private practice, getting a mental health appointment and seeing a doctor is often very difficult for patients with acute psychiatric symptoms. This study aimed at quantifying the time delay involved in seeking medical attendance when psychiatric disorders begin to develop. ***Methods:*** Two female actors with well-proven experiences of realistically simulating the clinical presentation of depression and psychotic disorders made systematic phone calls to 106 psychiatrists in private practice and 106 general practitioners (GPs) of the Zurich City area. The actors asked for an appointment at the doctor's earliest convenience due to acute psychiatric symptoms. We assessed (1) the number of phone calls it took to reach each doctor; (2) the time it took to book an appointment; (3) the time span between the first phone call and the earliest available appointment, and (4) the possibility of personal contact with a doctor prior to booking the appointment. ***Results:*** A total of 383 phone calls were made by the two actors (227 to psychiatrists and 156 to GPs) which resulted in analyzable data from 102 psychiatrist and 106 GP practices. Two thirds (68%) of the phone calls to the psychiatrists in private practice were answered by voice mail, compared to 21% among the GPs. A personal contact was established with 56% of the psychiatrists and 95% of the GPs. On average, 7.3 phone calls were necessary to successfully book an appointment with a psychiatrist. Almost half of the psychiatrists (45.6%) were not accepting new patients so appointments were able to be booked in less than one third of cases (30.4%). The situation was significantly better with GPs ($p < 0.002$) but depended on clinical diagnosis ($p < 0.01$). The waiting time to seeing a psychiatrist often far exceeded 7 days. ***Conclusions:*** A high density of psychiatrists in private practice does not necessarily improve the long and troublesome circumstances of obtaining a mental health appointment in acute psychiatric situations. Under these circumstances, a considerable proportion of patients might give up

A.O. is co-first author.

KARGER

Fax +41 61 306 12 34
E-Mail karger@karger.ch
www.karger.com

0254–4962/13/0463–0201$38.00/0

Accessible online at:
www.karger.com/psp

René Bridler
Sanatorium Kilchberg AG
Alte Landstrasse 70
CH-8802 Kilchberg
Tel. +41 44 716 4265, E-Mail r.bridler@sanatorium-kilchberg.ch

prior to seeing a doctor. This has important implications – many patients could miss the potential benefits from timely therapeutic interventions which can significantly modify both the acute and long-term course of the illness. The situation might be improved if psychiatrists and GPs joined forces in the form of group practices or networks as this would readily ensure (1) a rapid mental health triage by assessing and categorizing the urgency of mental health-related problems, and (2) timely therapeutic interventions whenever indicated.

Background

Every day, a substantial proportion of the general population experiences the distressing and frightening signs of an upcoming psychiatric illness, either in form of a first manifestation or a recurrent episode. Indeed, about 1 in every 8 women will develop clinical depression at some point during her lifetime, while lifetime prevalence in males is only slightly less. Similarly, schizophrenia and bipolar illness each affects about 1% of the general population. The consequences are enormous because severe psychiatric disorders typically cause the loss of the ability to work and often mean a grossly underestimated burden for family, friends, and peers. In addition, there is the socioeconomic burden that has to be carried by the patients themselves, their communities, and, given the high incidences, the economy as a whole [1]. Available treatments, though effective, are incomplete in so far as: (1) response rates are modest in terms of the proportion of patients in whom they induce remission; (2) concerning the benefits of psychopharmacological medications, there are significant risks associated with their use in terms of unwanted side effects; (3) given current knowledge, it is not possible to predict whether or not a particular patient will respond to a particular therapy, and (4) there is no cure for a considerable proportion of patients [2–4].

It is generally accepted that early detection and early intervention can considerably improve the acute and long-term course of psychiatric disorders: the exacerbation of the illness may be slowed down or even prevented, the severity of symptoms or symptom patterns may be positively influenced, thus leading to a more favorable outcome, hospitalization along with subsequent stigmatization may be avoided in a considerable number of cases, and the patients' insight, cooperation, and compliance can be expected to be much better [e.g. 5–7]. This latter point is critically important for intervention, as there is only a short time window when patients still have sufficient energy and insight to seek professional support and to start a therapy. Even though most developed countries have an exceptionally high density of general practitioners (GPs) and psychiatrists in private practice, getting a mental health appointment and seeing a doctor is often burdensome for patients with acute psychiatric symptoms. Many phone calls are necessary to find someone who is accepting new patients. This process can be demoralizing, especially for those in need of psychiatric help, leading to increased desperation [8].

Attempts to reorganize basic psychiatric care typically aim at lowering health care costs rather than catering to the patients' needs. Empirical research regarding the effectiveness and quality of current approaches to psychiatric care is insufficient, and very little information exists to help in understanding what exact aspects would improve it and make it more effective. In this study, we aimed to quantify the extent to which our primary psychiatric care system – consisting of GPs and psychiatrists in private practice – supports the concept of early detection and early intervention. Specifically, we tested the easiness of obtaining medical attendance when severe psychiatric symptoms begin to develop and the patient experiences first signs of an upcoming psychiatric disorder, with 'easiness' being quantified both in terms of the time involved for booking a medical appointment and the waiting time to see a doctor.

Methods

A comparative study was carried out in Zurich, with 375,000 inhabitants the largest city of Switzerland. The current density of psychiatrists in private practice and GPs per 100,000 of the population is 78 and 75, respectively. On February 17, 2010, there were 293 psychiatrists and 280 GPs registered in Zurich City. For the purpose of this investigation, we randomly selected 106 psychiatrists along with 106 GPs. Our randomization method was based on the two commercially available lists of these 293 and 280 physicians in private practice. We generated random permutations of these lists by means of the statistical program package SAS. The two permutated lists (i.e. randomly sorted) were then divided into 'half-lists' of 146 + 147 psychiatrists and 140 + 140 GPs. The first 54 entries of each psychiatrist and GP half-list were used for the study.

We were mainly interested in: (1) the number of phone calls necessary to reach each doctor; (2) the time necessary to book an appointment; (3) the time span between personal contact and the earliest possible appointment, and (4) the personal contact with a doctor prior to booking the appointment. To assess these data, we relied upon two female actors who are routinely involved as pseudo-patients in examinations of medical students at the Medical Faculty of the University of Zurich. Therefore, they have a great

deal of experience of realistically simulating the clinical presentation of depression and psychotic disorders. Each actress received a pair of mutually exclusive half-lists of 53 psychiatrists and 53 GPs. The half-lists were processed in a sequential way, parallel for psychiatrists and GPs.

Based on detailed vignettes of two virtual patients with acute symptoms of major depression or schizophrenia, the two actresses were trained and supervised by an experienced psychiatrist. The training involved a series of diagnostic interviews carried out by several psychiatrists who were naïve to the actresses' 'diagnoses'. An additional training was provided for the standardized procedure by which phone calls had to be conducted.

Between March 12 and April 19, 2010, each actress called 53 psychiatrists and 53 GPs and presented the following 'previous medical history': (1) at the age of 31 years: first manifestation of either a severe major depressive episode with suicidal ideation or a severe paranoid schizophrenia with catatonic symptoms; therefore hospitalized for several months; participated in a psychiatric education program on recognizing first signs and symptoms of an upcoming relapse; received a 'standby medication' (15 mg mirtazapine/10 mg olanzapine) to be used if things get unmanageably worse; (2) at the age of 34 years: second episode that could be treated through outpatient care due to timely therapeutic intervention; (3) current manifestation at the age of 39 years: symptoms emerged with continuous deterioration over the past 4 weeks after a significant life event (partner in life moved to a distant place of work); has taken standby medication the day before; (4) symptoms were presented as detailed as possible, suicidal ideation was denied; (5) every attempt was made to book an appointment at the doctor's earliest convenience. If she could book an appointment within the next 7 days (a waiting time of up to 7 days was regarded as acceptable in this study), the actress asked for peripheral hours in the evening or at the weekend. Otherwise, she tried to move the appointment forward to a somewhat earlier date. Appointments were cancelled at the end of the phone call giving logistical reasons.

A maximum of 3 phone calls per doctor was made during normal business hours. Whenever a call was answered by voice mail, the actresses noted down the office hours specifically given by the psychiatrists as 'time when they are personally reachable by phone'. The second phone call was then placed in exactly this time window. For practical reasons, we chose not to leave a message in the mailbox: a psychiatric interview typically takes more than just a few minutes and the actresses cannot simultaneously handle several returning calls from psychiatrists. Moreover, running a psychiatric office almost entirely by returning messages may work quite well with patients who are under medical treatment by this particular psychiatrist or GP. We do not think that this procedure is helpful in acute psychiatric situations when patients seek help and need timely psychiatric care.

Our statistical model included diagnosis (depression vs. schizophrenia) and type of medical specialization (GP vs. psychiatrist) as main effects in order to explain the primary outcome variable, i.e. the time span between first personal contact and earliest possible appointment. Nonparametric tests were used to analyze differences in main effects (SPSS17, Kruskal-Wallis, Mann-Whitney).

The study protocol was approved by the Ethics Committee of the Canton of Zurich.

Results

Due to incomplete data, 5 psychiatrists and 1 GP had to be excluded from further analysis; thus, the subsequent results are based on the available data from 102 psychiatrists and 106 GPs. Attempts to book a mental health appointment with psychiatrists in private practice turned out to be a troublesome and stressful business. In fact, two thirds (67.8%) of the phone calls to psychiatrists in private practice were answered by voice mail ('you may leave a message after the beep'). A personal contact with a psychiatrist, or the psychiatrist's receptionist, was in most cases very difficult to establish: 25 contacts at first attempt (24.5%), 16 contacts at second attempt (15.7%), and another 16 contacts at third attempt (15.7%). No personal contact was possible in 44.1% of the psychiatrists in private practice, while almost half of the psychiatrists (45.6%) with whom a personal contact could be established did not accept new patients.

Establishing a personal contact with a psychiatrist is by no means a guarantee of getting an appointment and of starting a therapy, even under acute psychiatric conditions. Many psychiatrists in private practice do not accept new patients at all, or only after a waiting time of several months. In consequence, it is not really surprising that in no more than 30.4% of cases were our test 'patients' successful in booking a mental health appointment with a psychiatrist (table 1).

By contrast, almost all GPs (95.3%) could be contacted personally, either through the doctor's receptionist or the doctor himself/herself. In 62.3% of cases, the first attempt was successful. Moreover, booking an appointment with a GP turned out to be a lot easier compared to psychiatrists in private practice. In total, 77 appointments with GPs could be booked by our test 'patients', which means that 76.2% of the GPs with whom a personal contact could be established accepted new patients (table 1). Of these appointments, 40.3% could be made outside of normal office hours (psychiatrists 41.9%).

Once appointments have been made, patients have to go through a long waiting time, which is particularly difficult to stand when symptoms are developing and the patients' situation deteriorates more and more. Even though acuteness and severity of symptoms were discussed in detail during the phone call, the average waiting time to seeing a psychiatrist in private practice was nonetheless found to be 6.1 days and, with 2.97 days, was only slightly shorter in the case of the GPs (table 2). The standard deviations in the range of 7 days along with mean values in the range of 6 days indicate that the wait-

Table 1. Phone calls and appointments

	Psychiatrists (n = 102)	GPs (n = 106)
Total number of phone calls	227	156
Answered by:		
Doctor	51	14
Receptionist/nurse	3	80
Other	3	9
Voice mail	154 (67.8%)	33 (21.1%)
Successful appointments	31 (30.4%)	77 (72.6%)

On average, 7.3 phone calls were necessary to successfully book an appointment with a psychiatrist, while half of the psychiatrists did not at all accept new patients. Appointments with psychiatrists could be booked in 30.4% of cases and with GPs in 72.6% of cases.

Table 2. Waiting time (days) to see a doctor

	Psychiatrists (n = 102)	GPs (n = 106)
Average waiting time	6.1 ± 6.6	3.0 ± 3.5
Waiting time for acute psychotic symptoms	5.5 ± 7.0	1.4 ± 2.0
Waiting time for acute depressive symptoms	6.7 ± 6.8	4.2 ± 3.9

Standard deviations in the range of 7 days along with mean values in the range of 6 days indicate that the waiting time to seeing a psychiatrist often far exceeded 7 days (7 days were regarded as acceptable in this study).

ing time to seeing a psychiatrist often far exceeded 7 days. The psychiatrist-GP differences reached statistical significance ($p < 0.002$).

As one would expect, the symptom pattern presented on the phone (affective vs. psychotic disorders) had a significant influence on the time to meeting with the doctor, while the severity of symptoms appeared to play a minor role. For patients reporting psychotic symptoms, the average time to seeing a psychiatrist was 5.47 days compared to 1.38 days in the case of GPs ($p < 0.0001$). By contrast, patients reporting a typical pattern of depressive symptoms had to wait longer compared to the patients with psychotic symptoms, and the difference in waiting time did not reach statistical significance (6.7 days to seeing a psychiatrist vs. 4.2 days to seeing a GP).

Discussion

Patients experiencing acute psychiatric symptoms with rapid deterioration typically feel disturbed and bewildered, are unsure of themselves, and do not know how to cope with the situation. Those who seek help are primarily seeking professional support along with therapeutic plans providing a long-term perspective, rather than to stay in a crisis intervention center overnight that might even amplify emotional instability.

The results of our study show that a high density of psychiatrists in private practice and a high density of GPs do not necessarily improve the ease with which patients can get a mental health appointment and see a doctor in acute psychiatric situations. A frustratingly large number of phone calls, many of which being answered by voice mail, are often necessary to set up a personal contact with a psychiatrist or a psychiatrist's receptionist. On average, 7.3 phone calls were necessary to successfully book an appointment, while half of the psychiatrists did not at all accept new patients. Even though the situation was better with the GPs, our data underline the fact that getting professional help in acute psychiatric situations can become really demoralizing. Under these circumstances, a considerable proportion of patients is likely to give up prior to seeing a doctor, thus missing the potential benefits from timely therapeutic interventions which might sig-

nificantly improve both the acute and long-term course of the illness.

The situation is similar in other developed industrial countries [9, 10]. This may have to do with the fact that the majority of psychiatrists in private practice do not understand themselves as primary care providers but rather as 'specialists' with whom appointments have to be booked months in advance. The lack of timely access to medical attendance in situations when severe psychiatric symptoms begin to develop elevates the risk for health deterioration, treatment refusal, unnecessary hospitalizations, or even fatal outcomes. By contrast, a reduction of the waiting time to the initial psychiatric consultation typically leads to a highly significant reduction of psychiatric hospitalizations ($p < 0.001$), along with additional positive effects [11].

A personal contact can almost always be established with a GP, and in 75% of the cases a mental health appointment can be booked. Consequently, basic psychiatric care appears to be increasingly covered by GPs whose psychiatric training is often rudimentary, so that this is not really an option for long-term therapeutic support. This situation is quite unsatisfactory from the patients' point of view.

Finally, it could be that the situation might be improved by psychiatrists and GPs joining forces to form group practices or networks. This is a model that has already been successfully implemented at several places [12–14]. Given the general cost pressure on health care systems, this latter approach is likely to gain increasing attention in the near future as current attempts to lower health care costs clearly favor managed care models [e.g. 15].

Conclusions

The use of voice mail, in lieu of having a person answering the phone, appears to be the de facto standard among psychiatrists in private practice. Clearly, unnecessarily long waiting times should be avoided in situations where timely interventions have the potential to improve the acute and long-term course of psychiatric disorders. This central point of primary psychiatric care deserves more attention since the situation might be improved if psychiatrists and GPs join forces to form group practices or networks. In doing so, they could readily ensure (1) a rapid mental health triage by assessing and categorizing the urgency of mental health-related problems, and (2) timely therapeutic interventions whenever indicated.

Acknowledgements

We thank Karin V. Rhodes for her valuable help in planning and setting up this study, and the two actresses, Rosmarie Hauser and Cristina Müller-Lubini, for the dedicated performances as patients.

References

1 WHO Resource Book on Mental Health, Human Rights and Legislation. WHO, 2005.
2 Stassen HH, Angst J, Hell D, Scharfetter C, Szegedi A: Is there a common resilience mechanism underlying antidepressant drug response? Evidence from 2,848 patients. J Clin Psychiatry 2007;68:1195–1205.
3 Szegedi A, Jansen WT, Van Willigenburg AP, Van der Meulen E, Stassen HH, Thase ME: Early improvement as a predictor of treatment outcome in patients with major depressive disorder: why the first 2 weeks really matter – evidence from 6,562 patients. J Clin Psychiatry 2009;70:344–353.
4 Stassen HH, Anghelescu IG, Angst J, Böker H, Lötscher K, Rujescu D, Szegedi A, Scharfetter C: Predicting response to psychopharmacological treatment. survey of recent results. Pharmacopsychiatry 2011;44:263–272.
5 Christodoulou GN, Christodoulou NG: Early intervention in psychiatry. Early Interv Psychiatry 2007;1:7–8.
6 Brenner R, Madhusoodanan S, Puttichanda S, Chandra P: Primary prevention in psychiatry – adult populations. Ann Clin Psychiatry 2010;22:239–248.
7 Pedrelli P, Farabaugh AH, Zisook S, Tucker D, Rooney K, Katz J, Clain AJ, Petersen TJ, Fava M: Gender, depressive symptoms and patterns of alcohol use among college students. Psychopathology 2011;44:27–33.
8 Rhodes KV, Vieth TL, Kushner H, Levy H, Asplin BR: Referral without access: for psychiatric services, wait for the beep. Ann Emerg Med 2009;54:272–278.
9 Goldner EM, Jones W, Lan Fang M: Access to and waiting time for psychiatrist services in a Canadian urban area: a study in real time. Can J Psychiatry 2011;56:474–480.
10 Boyd JW: The crisis in mental health care: a preliminary study of access to psychiatric care in Boston. Ann Emerg Med 2011;58:218–219.
11 Williams ME, Latta J, Conversano P: Eliminating the wait for mental health services. J Behav Health Serv Res 2008;35:107–114.
12 Collins KA, Wolfe VV, Fisman S, DePace J, Steele M: Managing depression in primary care: community survey. Can Fam Physician 2006;52:878–879.
13 Fleury MJ, Bamvita JM, Aubé D, Tremblay J: Clinical practice settings associated with GPs who take on patients with mental disorders. Healthc Policy 2010;5:90–104.
14 Kates N, McPherson-Doe C, George L: Integrating mental health services within primary care settings: the Hamilton Family Health Team. J Ambul Care Manage 2011;34:174–182.
15 Regestein QR: Psychiatrists' views of managed care and the future of psychiatry. Gen Hosp Psychiatry 2000;2:97–106.